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MANDATORY ETHICS AND JURISPRUDENCE TRAINING: DOES IT MAKE A DIFFERENCE IN DISCIPLINARY ACTIONS OF OCCUPATIONAL THERAPY PROFESSIONALS?

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A Dissertation Submitted to the Faculty of the
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ABSTRACT

There have been few studies examining disciplinary actions by state boards of occupational therapy. Researchers have mainly studied mandatory continuing competence but not the influence of mandatory ethics and jurisprudence training. This study is based on disciplinary reports between January 2004 and December 2012 for Tennessee and Alabama State Boards of Occupational Therapy.

The first of two research questions asked if there was a difference in the percentage of disciplinary reports for occupational therapy practitioners licensed in Tennessee who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners in Tennessee prior to mandated ethics and jurisprudence training.

The second research question asked if there was a difference in the percentage of disciplinary reports for the occupational therapy practitioners in Tennessee who received mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners licensed in Alabama who did not receive mandatory ethics and jurisprudence training.

Results indicate that mandatory ethics and jurisprudence training did not result in a decrease in disciplinary reports, however, the data may not be telling the entire story. The initiation of mandatory continuing competence in Tennessee may have influenced the outcome

of this study. Study findings are discussed in terms of implications of the results and projections for future research.

DEDICATION

This work is dedicated first to my parents, John and Peggy Spratling, who first introduced me to the meaning of ethics by teaching and demonstrating the difference between right and wrong. They continuously amaze me with their unconditional love and support. This dissertation is also dedicated to my husband, David, and children, Paul and Beth. I hope I have made you proud.

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CHAPTER I

INTRODUCTION

"Ethics is knowing the difference between what you have a right to do and what is right to do".
Potter Stewart (2013)

The words ethic and ethnic have a common origin in the Greek word etho, meaning to be accustomed to or to be in the habit. From etho came the derivatives: (a) ethos, custom, habit; and (b) ethnos, a number of people accustomed to living together (Merriam-Webster, 2013). The word ethnic has assumed a broader definition – associated with culture – whereas the more narrowly defined word ethic describes one aspect of culture. In the ancient Greek world, the words ethical and moral came from the same expression, and were used synonymously. At that time, to be ethical and moral were not merely habitual ways of acting; both terms referred to behaviors that were approved by a larger group or society. The separate meanings of ethics and morals came when the Romans translated the Greek into ethics and used mores, the plural form of mos, which means character, behavior, customs, and laws. From the Roman model, the words moral and ethic continue to have separate meanings, with ethics being a subset of morality.

The practice of healthcare goes beyond technical competence; all practitioners must also attend to the ethical, legal, and professional requirements of their roles. Practitioners who fail to master these duties will be a continual frustration to those who must work with them and will also find themselves facing sanctions for their inappropriate or illegal behaviors.

Legal requirements ensure that a professional follows a set of principles and processes by which the occupation settles disputes and problems without resorting to force or violence. In a sense, law can be considered the minimum standard of expected performance between individuals in a society. To ensure that healthcare practitioners abide by the basic standards, state practice acts and codes of professional ethics contain rules that require the individual to comply with the regulation for professional conduct.

Statement of the Problem

When healthcare professionals demonstrate illegal and unethical behaviors and actions, state licensing boards determine disciplinary actions. Information about disciplinary actions for occupational therapy professionals is useful to state regulators, policymakers, managers, members of the profession, and educators of occupational therapists and occupational therapy assistants. Multiple studies are found in medicine that reported common violations. Papadakis, Hodgson, Teherani & Kohatsu (2004) reported a relationship between unprofessional behavior in medical school and subsequent disciplinary actions by state medical boards. The literature also includes discussion about the important relationship between academic integrity and professional behavior (Mohr, Ingram, Fell, & Mabey, 2011). Published articles about the unprofessional conduct of occupational therapists are few. Many state regulatory boards publish records of sanctioned occupational therapists and the federal government tracks sanctioned health professionals; however, descriptive statistics about disciplined occupational therapists across the nation are limited. This research will synthesize the actions of Tennessee and Alabama state regulatory boards against occupational therapists and occupational therapists for unprofessional conduct. This investigation will add to the literature by providing information about sanctioned

licensed occupational therapy professionals, their unprofessional behavior, and provide suggestions for enhancing practice and reducing exposure to ethics complaints by occupational therapy practitioners.

Purpose of the Study

This research presents the results of a descriptive investigation synthesizing the data from the Tennessee State Board of Occupational Therapy and the Alabama State Board of Occupational Therapy. The study first examined the disciplinary actions sanctioned by the Tennessee State Board of Occupational Therapy for the years of 2004-2012. The study compared disciplinary reports before mandatory ethics and jurisprudence (E & J) courses were mandated to disciplinary reports sanctioned after mandatory ethics and jurisprudence training. The data were compared to disciplinary reports of the Alabama State Board of Occupational Therapy during the same time frame of nine years (2004-2012). The purpose of the study was to determine whether the mandated ethics and jurisprudence courses resulted in a decrease in disciplinary reports by the Tennessee State Board of Occupational Therapy. In addition, these data were compared to data from the Alabama State Board of Occupational Therapy, which did not have mandatory ethics and jurisprudence training required for licensed occupational therapy professionals in their state.

Research Question and Hypothesis

Question One*:* Is there a difference in the percentage of disciplinary reports for occupational therapy professionals licensed in Tennessee who participated in mandatory ethics

and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners in Tennessee prior to mandated ethics and jurisprudence training?

Hypothesis*:* There will be a decrease in the percentage of disciplinary reports for occupational therapy professionals after the Tennessee State Board of Occupational Therapy mandated ethics and jurisprudence training.

Null Hypothesis: There will be no difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who participated mandatory ethics and jurisprudence training when compared to disciplined occupational therapy practitioners in Tennessee prior to mandated ethics and jurisprudence training.

Question Two: Is there a difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who received mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals licensed in Alabama who did not receive mandatory ethics and jurisprudence training?

Hypothesis: There will be a lower percentage of disciplinary reports for occupational therapy professionals in Tennessee who received mandatory ethics and jurisprudence training compared with occupational therapy practitioners in Alabama who did not receive mandatory ethics and jurisprudence training.

Null Hypothesis: There will be no difference in the percentage of disciplinary reports between occupational therapy professionals from Tennessee who have received mandatory ethics and jurisprudence training and occupational therapy practitioners from Alabama who have received no mandatory ethics and jurisprudence training.

Rationale for the Study

Currently there are few published studies synthesizing the sanctions of unprofessional behavior of occupational therapy professionals. The results may be helpful to state regulatory boards, policymakers, and members of the profession, as they consider including ethics and jurisprudence requirements for licensure renewal. This research specifically focused on the influence of required ethics and jurisprudence instruction on the behavior of licensed occupational therapy professionals in the state of Tennessee.

Theoretical/Conceptual Framework

Ethics guide the determination of right and wrong in moral life. Healthcare professionals often are faced with choices in situations that arise in practice and have to deal with moral issues. In order to better understand ethical concerns, further knowledge of ethical theories, terminology and concepts are required to improve an understanding of the theoretical framework on which to base this study.

An understanding of ethics theory is useful in healthcare decision-making. Healthcare professionals face many issues in dealing with the complexities of both patient treatment and the larger healthcare system. Dealing with these issues requires a solid foundation of knowledge and skills. This is also true with the study of ethics. Ethics in healthcare is not just about doing the right thing. The issues are often multifaceted and far from clear-cut. A firm base in the theory and principles of ethics will aid the healthcare professional in making appropriate and proficient decisions. These theories will be discussed further in the literature review.

Significance/Importance of the Study

Currently there are no organized efforts to publicize information regarding disciplinary actions taken against occupational therapy professionals. State licensing boards have the option of reporting disciplinary actions to the American Occupational Therapy Association and the National Board for Certification in Occupational Therapy (NBCOT). State regulatory boards are required to report disciplinary actions to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

The Health Care Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB) were created by the Health Care Quality Improvement Act of 1986 (HCQIA) Title IV of P.L. 99-660 as amended and implemented in 1990. The HIPDB and the NPDB are two federal data banks that have been created to serve as repositories of information about healthcare providers in the United States. Federal law requires that adverse actions taken against a healthcare professional's license be reported to these data banks. Some of the information included in the NPDB and HIPDB are not available to the general public. The latest NPDB Summary Report for 2012 reports that Medical Malpractice Reports for occupational therapists from September 1, 1990 through November 25, 2012 revealed the following: Alabama two and Tennessee three (U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions Division of Practitioner Data Banks, 2012). ProPublica (2012) reported some states failed to report disciplined caregivers to federal databases. Law requires all states, to report the licensed healthcare workers they have sanctioned to databases run by the U.S. Health Resources and Services Administration (HRSA). But ProPublica (2012) found that many state agencies either did not know about the requirement or simply were not complying. Officials attempted to

correct the omission of information by comparing disciplinary actions reported to the federal databases to the information states had listed on their own state's public websites. As an example, the information included in the 2012 NPDB Summary Report did not correlate with information found on the Tennessee State Board of Occupational Therapy website; therefore this federal database was not used utilized to gather data.

The importance of this study was that it will add to the body of knowledge for occupational therapy concerning mandatory ethics and jurisprudence training and the effect on disciplinary reports in two states. This study creates an initial collection of disciplinary reports for occupational therapy professionals in two southern states, Tennessee and Alabama.

Definitions

The following terms and definitions apply to this study.

Autonomy: the right of an individual to self-determination; the ability to independently act on one's decisions for their own well being (Beauchamp & Childress, 2001).

Beneficence: doing good for others or bringing about good for them; the duty to confer benefits on others.

Confidentiality: not disclosing data or information that should be kept private to prevent harm and to abide by policies, regulations and laws.

Dilemma*:* a situation in which one moral conviction or right conflicts with another; a quandary exists because there is no one clear-cut, right answer.

Duty: actions required of professionals by society or actions that are self-imposed.

Ethics: the values and norms, which are assumed and taken for granted in a given cultural, professional, or institutional setting; ways of determining right and wrong (i.e., rules of conduct that are grounded in philosophical principles and theory).

Fidelity: faithfully fulfilling vows and promises, agreements, and discharging fiduciary responsibilities (Beauchamp & Childress, 2001).

Jurisprudence: case law, or the legal decisions which have developed and which accompany statutes in applying the law against situations of fact.

Justice (three types):

Compensatory – making reparation for wrongs that have been done

Distributive justice – the act of distributing goods and burdens among members of society

Procedural justice – ensuring that processes are organized in a fair manner and policies or laws are followed

Morality*:* personal beliefs regarding values, rules, and principles of what is right or wrong; may be culture-based or culture-driven.

Moral righteousness: is someone or something that is in accordance with high moral standards; acting in a just, upright manner; doing what is right; virtuous (American Heritage Dictionary, 2010).

Nonmaleficence: not harming or causing harm to be done to oneself or others; the duty to ensure that no harm is done.

Veracity*:* a duty to tell the truth; avoid deception.

CHAPTER II

REVIEW OF THE LITERATURE

To understand the history and theory of ethics, codes of ethics in healthcare and occupational therapy, continuing competence for healthcare providers and mandatory continuing education and continuing competence for healthcare professionals, regulatory agencies for occupational therapy, and ethics educational training for healthcare professionals, an examination of the literature was reviewed on these topics. This analysis offers an overview of the history of ethics in healthcare and more specifically to occupational therapy. Examination of mandatory continuing education is presented with attention to the issue for occupational therapy. A review of the various regulatory agencies for occupational therapy is discussed and their jurisdiction over occupational therapists and occupational therapy assistants. Finally the analysis of literature provided attention to other healthcare professions regarding disciplinary actions and mandatory ethics training as well as occupational therapy. Currently the literature in occupational therapy on the relationship between mandatory ethics training and ethical violations in the profession is almost non-existent. The goal of this study was to provide important evidence for the occupational therapy profession.

Theories of Healthcare Ethics

An understanding of ethics is critical in a healthcare professional's knowledge base. Knowledge of ethics supports decision making for healthcare professionals when faced with

ethical dilemmas in their daily practice. Theories provide support for ethical understanding and ethical decision-making. Ethical philosophy and principles provide a language for diagnosing, communicating and problem-solving ethical questions. Ethical hypotheses are well-developed, systematic frameworks of rules and principles (Nash, 2002). These ethical premises provide ideals for ethical standards. There are many ethical approaches and assumptions that serve as reference points for guiding decision making. In healthcare, the most commonly used ethical approaches are principle-based approaches, virtue and character-based ethics, utilitarianism, and deontology.

Principle-based approaches to ethics depend on ordinary shared moral beliefs as theoretical content. Principles are duties, rights, or other moral guidelines that provide a logical approach to analyzing ethics issues for a given situation.

Character-based ethics and virtues are dispositions of character and conduct that motivate and enable practitioners to provide good care (Fletcher, Miller, & Spencer, 1997). Virtue ethics from Aristotle and Thomas Aquinas focus on moral agents and their good character. In this approach, moral goodness is achieved when behaviors are chosen for the sake of virtue (caring and kindness) rather than obligation.

Utilitarianism results from the work of Jeremy Bentham and John Stuart Mill and is concerned with actions that maximize good consequences and minimize bad consequences. This perspective sees morally right acts in general as those that produce the best results. Therefore, the ends justify the means. The ethical action is one where the outcome brings about the most good or the least harm overall (Purtilo & Doherty, 2011).

Deontology is a duty-based moral theory based on the ideas of Immanuel Kant (Ciulla, 2003). This theory accepts as true that moral rules are universal and never to be broken;

consequently, doing one's duty is considered primary. This theory focuses on strictly following rules and principles of ethics, such as respect for autonomy, nonmaleficence, beneficence, justice, and other moral factors previously discussed. Adherence to the Ten Commandments demonstrates a deontological approach to ethics. From a Kantian viewpoint, respect for people is a moral imperative; therefore, withholding the truth disrespects the patient's right to know.

History of Ethics in Healthcare

In the past, ethics was referred to almost entirely as a collection of components from philosophical and religious fields. From an historical view, medical or healthcare was considered humanitarian, if not a charitable effort. Often members of religious communities provided the healthcare and others considered the service as being generous of spirit, caring in nature, courageous, dedicated, and self-sacrificing in their service to others. For many years, healthcare organizations, physicians, nurses, and other healthcare providers were considered to be charitable and for the most part immune from legal action (Lesnik & Anderson, 1962).

Although there are numerous court records of lawsuits involving hospitals, physicians, nurses and healthcare providers dating back to the early 1900's, those numbers do not compare with the volumes being generated in recent years (Reising & Allen, 2007). Over the years, legal authorities, such as federal and state governments, maintained a lenient attitude when it came to issues of biomedical research or physician-patient relationships. This changed with the atrocities committed during World War II. These cruel acts were also executed in the United States with the treatment of syphilitic African Americans in Tuskegee, Alabama and the use of institutionalized mentally retarded children to study hepatitis at the Willowbrook State School on Staten Island, New York (Kirschner, 2006).

Due to these and other disturbing incidents, in 1974 Congress created the National Commission for the Protection of Human subjects of Biomedical and Behavioral Research (U.S. Department of Health and Human Services, 1983). An outcome of this act was an institutional review board for the protection of human subjects, which was rapidly established at the local level by any hospital, academic medical center, agency, or organizations where research on human subjects was being conducted.

Purtilo (1977) observed that a code of ethics serves two important functions. One function is to legitimize the claim that an occupational group has attained the status of being a profession. The second function is to provide guidance for practitioners. Purtilo (1977) stated that the test of a true code of ethics is having a true ethical standard.

Not all healthcare professions waited until the 1970's to establish uniform standards for professional training and conduct. The first was the American Medical Association (AMA), which wrote and published a Code of Medical Ethics in 1847; the code is currently in its fifth revision (American Medical Association, 2013). All five versions address the precedence of the patient's welfare and physicians' moral righteousness over scientific accomplishment and professional gain.

The Pledge of Florence Nightingale is published in a nursing textbook that is mostly a compendium of etiquette and proper behavior for her "girls", as she called them (Purtilo, 1977, p. 1003). Florence Nightingale's Pledge was the first document suggesting that any professional group providing health care, besides that of physicians, needed or wished to include as part of its working definition, some formal statement about ethics conduct.

In 1950, the American Nurses Association (ANA) developed and adopted an ethical code for professional practice that has been revised and updated several times (American Nurses

Association, 2001, 2007). Most healthcare professional organizations have traditionally taken responsibility for establishing standards of ethical behavior for members of their disciplines.

In 1935, the American Physical Therapy Association, then the American Physiotherapy Association, adopted its first Code of Ethics and Discipline (Swisher, Hiller & the APTA Task Force to Revise the Core Ethics Documents, 2010). This was a statement of the members of this organization, acknowledging that they wanted to formalize their ethical position. The development and revisions of professional ethics are very complex. Social and psychological factors and economic pressures and demands of a technologically advanced form of health care delivery all have significant influences on the development and revision of ethical codes of practice for healthcare professionals (Swisher et al., 2010).

History of Ethics in Occupational Therapy

The historical progressions of codes of ethics create a path for the discussion of the development of a code of ethics in occupational therapy. Two statements predated the first version of the Occupational Therapy Code of Ethics, published in 1977. William R. Dunton, Jr. M.D. authored the first statement in 1919; he used occupation as a curative and preventive agent (Scott & Reitz, 2013). A committee of the National Society developed the second statement, the Basic Principles of Occupational Therapy, for the Promotion of Occupational Therapy (the name was changed to American Occupational Therapy Association in 1921). These principles were published in 1919 and reprinted periodically until 1940 (Reed, 2011). There is much speculation on why the principles were not reprinted after 1940 (Slater, 2011). Some of the possible reasons could have been the disruption caused by World War II and the profession's focus on contributions to the war effort. After World War II, the practitioners were busy establishing the

profession by branding the term occupational therapy and other professional terms, fighting against licensure, and developing entry-level degrees, among other activities (Reed, 2011).

The American Occupational Therapy Association's (AOTA) *Occupational Therapy Code of Ethics and Ethics Standards* is a public statement of principles with the purpose to promote and maintain high standards of conduct within the profession (AOTA, 2010a). AOTA first adopted a code of ethics in 1977. The Code of Ethics was then revised in 1979, 1988, 1994, 2000, and 2010. The revisions to the Code occurred in response to societal changes and AOTA's systematic review process for its entire official documents to ensure that they continue to be relevant. The Occupational Therapy Code of Ethics was once Hippocratic in nature but has since evolved into a sociological model of ethical conduct. The historical foundation of this Code and Ethics Standards is based on ethical reasoning surrounding practice and professional issues, as well as on empathic reflection regarding these interactions with others (AOTA, 2005a, 2006). While a great deal has changed over the course of the profession's history, more has remained the same. The profession of occupational therapy remains grounded in seven core concepts as identified in the Core Values and Attitudes of Occupational Therapy Practice (AOTA, 1993): altruism, equality, freedom, justice, dignity, truth and prudence. These values define the ethical principles that the profession is committed to and the public can expect. The Code and Ethics and Ethics Standards apply to AOTA members at all levels in professional roles such as practitioner, educator, fieldwork educator, clinical supervisor, manager, administrator, consultant, faculty, program director, researcher or scholar, private practice owner, entrepreneur, student and others, including elective and appointed volunteer roles with AOTA.

Code of Ethics

Healthcare professionals often take an oath to follow a strict code of ethics. This has been true since the fourth or fifth century when the Hippocratic Oath was composed (Hulkower, 2009/2010). While the code has changed with the times, the code of ethics for healthcare professionals still dictates a commitment both to patients and to other healthcare professionals. A healthcare professional is accountable to superiors, colleagues, patients and the general public, and has moral obligations to these people.

Healthcare ethics are a set of moral principles, beliefs and values that guide professionals in making choices about medical care. At the core of healthcare ethics is a sense of right and wrong as well as beliefs about rights individuals possess and duties owed to others. McCormack, at the University of Washington, (1998), subscribes to the opinion that in the United States, four main principles define the ethical duties healthcare professionals owed to patients. They include: autonomy, beneficence, non-maleficence and justice.

First is respect for autonomy of the patient. People have the right to control what happens to their bodies. This principle means that an informed, competent adult patient can refuse or accept medical treatment. Everyone must respect these decisions, even if those decisions are not in the best interest of the patient.

Beneficence involves promoting what is best for the patient. All healthcare providers strive to improve their patient's health, to do the most good for the patient in every situation.

Non-maleficence means first do no harm. This is the foundation of medical ethics. In every situation, healthcare providers should avoid causing harm to their patients.

Justice is the fourth principle that requires the healthcare professional to try and be as fair as possible when offering treatments to patients and allocating scarce medical resources (McCormick, 1998).

Occupational Therapy Code of Ethics

The Occupational Therapy Code of Ethics and Ethics Standards (AOTA, 2010a) provides a guide for professional conduct, along with The Standards of Practice for Occupational Therapy (AOTA, 2010b). The Standards document is a resource available to all occupational therapy practitioners, educators, students, and researchers, encouraging them to achieve the highest level of professional behavior. The purpose of the Occupational Therapy Code of Ethics and Ethics Standards (AOTA, 2010a) is to:

- Identify and describe the principles supported by the occupational therapy profession;
- Educate the general public and members regarding established principles to which occupational therapy personnel are accountable;
- Socialize occupational therapy personnel to expected standards of conduct; and
- Assist occupational therapy personnel in recognition and resolution of ethical dilemmas. (p. 152)

The American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics (Slater, 2011) identifies standards that support regulatory bodies and licensing of occupational therapy practitioners. Licensure laws and the AOTA Code are necessary to protect recipients of services, the practitioner, and the profession. This belief is reinforced in AOTA's Reference Guide to the Occupational Therapy Code of Ethics, "any action in violation of the spirit and purpose of this Code shall be considered unethical" (AOTA, 2003, p. 10).

Most states have achieved regulatory status for occupational therapy professionals. This required extensive lobbying and legislative efforts. This collaborative effort between AOTA and

state associations was instrumental in assisting states to achieve this professional status. The author completed a review of occupational therapy practice acts in the United States which revealed the following: eighteen states use the AOTA Code of Ethics as the ethical guide in their practice acts, nine have developed their own code of ethics, but have used the AOTA Code of Ethics in principle and spirit or they are an adapted version, and twenty three states have developed their own rules of professional conduct.

Mandatory Continuing Education/Continuing Competence in Healthcare

Healthcare regulatory bodies are charged with protection of the public from the unsafe practices of healthcare professionals. Licensure testing has become an accepted means of assuring entry-level competence for most healthcare providers. However, effective evaluation of ongoing competence is a greater challenge. In 2002, the National Council of State Boards of Nursing (NCSBN) Research Department developed a study to explore if a link existed between mandatory continuing education (CE) and the development of professional competence (Smith, 2003). The NCSBN was joined by regulatory agencies for medical technologists, occupational therapists, physician assistants, physical therapists and respiratory therapists through the Interprofessional Workgroup for Health Professions Regulation (IWHPR). The CSBN study found seven conclusions: a) nurses tend to accumulate CE hours whether or not they are required, b) nurses with a CE mandate attend more hours of CE unrelated to their work or interests, c) nurses consider work experience as the greatest contributor to their current levels of ability, d) those nurses with and without CE mandates estimate the same levels of growth in ten professional abilities, e) access to CE and other factors related to professional learning varies among nurses in different work settings and possibly among nurses in different population

settings, f) nurses with CE mandates may have greater access to some sources of CE such as CE vendors because those providers target nurses with mandates, and g) nurses in lower population areas experience less growth in some abilities than do those in more populous regions (Smith, 2003).

Continuing competence has been a concern of health professionals since the consumer movements in the 1960's and increased with the evolution of reforms in the 1970's. Perhaps the most influential movements in continuing competence were the Pew Health Profession Commission Reports of 1995 and 1998. They argued that the accumulation of continuing education required by disciplinary boards did not ensure competence. States were advised to develop definitions of competence and criteria that private sector competence assessments would be deemed to satisfy state requirements. As a result of the Pew reports, many regulatory boards and professional associations began to struggle with approaches to assure continuing competence, including legislation to mandate continuing education.

Continuing competence is a challenge for healthcare professionals. Four major issues are frequently referred to in the literature: a) the definition and evaluation of continuing competence, b) core competencies and specialized practice, c) goals and responsibilities for ensuring continuing competence, and d) the economics of continuing education.

More recent research by Robertson, Umble, & Cervero in 2003, identified fifteen research syntheses (systematic reviews), published after 1993, in which primary continuing education studies were evaluated and the performance of healthcare professionals or patient health outcomes were examined. Their findings confirmed previous research indicating that continuing education could improve knowledge, skills, attitudes, behavior, and patient health outcomes (Robertson, et al., 2003). In addition, they suggested that, "On the research front,

primary studies and syntheses no longer need to ask if continuing education, in general, improves practice or other outcomes because there is so much evidence that many kinds and combinations of continuing education can do so" (Robertson, et al., 2003, p. 154).

Mandatory Continuing Education/Continuing Competence in Occupational Therapy

In occupational therapy, the purpose of professional training and credentialing is to protect the public by assuring practitioner competence. Derived from the Latin competo [to be suitable or to be adequate] competence implies meeting minimum standards, but not a particular position along a continuum of excellence (Latdict, 2013). Minimum standards, therefore, protect the public but do not ensure quality. Although initial competence requires occupational therapy practitioners to demonstrate a mastery of entry-level concepts on credential examinations, continuing competence was considered for years to be an internal aspect of professionalism; individual occupational therapists and occupational therapy assistants were expected to assure they were keeping current in the field. The principle of continuing competence has been addressed in earlier versions of the Occupational Therapy Code of Ethics. Of the seven principles of the Occupational Therapy Code of Ethics and Ethics Standards (AOTA, 2010a), Principle 5 notes: "Occupational therapy personnel shall comply with institutional rules, local, state, federal, and international laws and AOTA documents applicable to the profession of occupational therapy" (p. 7). Specific duties for occupational therapy practitioners (AOTA, 2010a) listed under this principle include:

> c) Be familiar with revisions in those laws and AOTA policies that apply to the profession of occupational therapy and inform employers, employees, colleagues, students, and researchers of those changes.
> d) Be familiar with established policies and procedures for handling concerns about the Code of Ethics Standards, including familiarity with national, state, local, district, and territorial procedures for handling ethics complaints as well as

> policies and procedures created by AOTA and certification, licensing, and regulatory agencies.
> f) Take responsibility for maintaining high standards and continuing competence in practice, education, and research by participating in professional development and educational activities to improve and update knowledge and skills. (p. 6 & 7)

Continuing competence in occupational therapy has moved from an internalized feature of professionalism to being explicitly addressed in the profession's code of ethics. Yerxa's (1967) conclusion on professional authenticity proclaimed the profession's official stance of planning and documenting achievement of competence beyond entry level. The ethical aspect is natural in continuing competence; ethical reasoning is emphasized as one of the five continuing competence standards (AOTA, 2005b). According to AOTA State Affairs Group of the fifty states and Washington, D.C., forty-three states have mandatory continuing competence and eight have no requirement for continuing competence (AOTA, 2012). Continuing competence is an entrenched principle of professionalism for occupational therapy professionals.

The Tennessee State Board of Occupational Therapy began enforcing continuing competence requirements for all applicants on January 1, 2008. This mandate was required for the renewal of licensure, reactivation of licensure, or reinstatement of licensure for all licensed occupational therapists in Tennessee. Tennessee licensed occupational therapy professionals must complete twenty-four continued competency credits for the two years preceding the date of the two year license renewal. According to the Tennessee General Rules Governing the Practice of Occupational Therapy (Rule 1150-02-.12):

> Occupational Therapists and Occupational Therapy Assistants are required to complete twenty-four (24) continued competence credits for the two (2) calendar years (January 1 – December 31) that precede the licensure renewal year.
> One (1) hour of the required twenty-four (24) continued competence credits shall pertain to the AOTA Code of Ethics or ethics related continued competence activities, which have implications for the practice of occupational therapy.
> One (1) hour of the required twenty-four (24) continued competence credits shall pertain to the occupational therapy portions of T.C.A. §§ 63-13-101, et seq., of the Tennessee

> Occupational Therapy Practice Act, and shall pertain to Chapter 1150-02 General Rules Governing the Practice of Occupational Therapy. (p.28)

The Alabama State Board of Occupational Therapy became a licensing board for all occupational therapy practitioners in the State of Alabama in 1990. Continuing education unit (CEU) requirements for occupational therapists and occupational therapy assistants were required at the inception of the law. The Alabama Practice Act states:

> An Occupational Therapist must obtain 1.5 CEU's (or 15 contact hours) annually or 3.0 CEU's (or 30 contact hours) biennially. No more than 1/3 of continuing education credits may be administration/management/ academic related with the remainder related to direct patient treatment. No more than a 1/3 hours can be generated by the therapist's professional presentations.
> (2) An Occupational Therapy Assistant must obtain 1.0 CEU (or 10 contact hours) annually or 2.0 CEU's (or 20 contact hours) biennially. No more than 1/3 of continuing education credits may be administration/ management/academic related with the remainder related to direct patient treatment. No more than a 1/3 hours can be generated by the therapist's professional presentations. (Alabama State Board of Occupational Therapy, Rules and Regulations, 2013b)

Regulatory Agencies for Occupational Therapy

Three entities have jurisdiction over matters relating to ethical and professional conduct of occupational therapy professionals, the American Occupational Therapy Association (AOTA), the National Certification Board for Occupational Therapy (NBCOT), and state regulatory boards (SRBs). AOTA, NBCOT and SRBs are all concerned with the ethical practice of occupational therapy. Jurisdiction depends on the degree of authority that the organization or agency has over the certificant, applicant, occupational therapy practitioner, or AOTA member. The consequences of ethical and legal misconduct vary across jurisdictions. Stakeholders, (NBCOT certificants, consumers, professionals) may report unethical practice to any of the three entities; however, the complaint would move forward for review only if it fell under the jurisdiction of the entity. If the board or organization reviewing the complaint determines that

the complaint is not within its jurisdiction, the complainant is notified in writing. Some actions subject to disciplinary action by one organization also are within the jurisdiction of another.

AOTA is a voluntary membership organization that represents and promotes the profession and the interests of individuals who choose to become members. AOTA has no direct authority over occupational therapists or occupational therapy assistants due to the voluntary membership aspect. There is no direct legal path for AOTA from preventing nonmembers who are incompetent, unethical, or unqualified from practicing; only state regulatory boards have that authority.

The National Board for Certification in Occupational Therapy (NBCOT) is a private, not-for-profit, non-governmental credentialing organization that oversees and administers the entry-level certification examination for occupational therapists and occupational therapy assistants. The certification examination is what the SRBs use as one of the criteria for licensure. NBCOT uses the examination as one of the criteria for initial certification. States or jurisdictions commonly require occupational therapists and occupational therapy assistants to be initially certified (i.e. pass the NBCOT entry-level certification exam) before they can qualify for a license. Most states or jurisdictions, however, do not require practitioners to renew this certification to maintain their licenses to practice (Slater, 2011).

NBCOT does not use AOTA's Code and Ethics Standards as a guide in reviewing complaints about incompetence or impaired practitioners but has a specific set of procedures for disciplinary action. NBCOT takes action when there is clear violation of its Candidate/Certificant Code of Conduct (National Board for Certification in Occupational Therapy, 2010). The three main categories that warrant disciplinary action are incompetence, unethical behavior, and impairment.

State regulatory boards (SRBs) are public bodies created by state legislature to ensure the health and safety of the citizens of that state and to enforce the state's occupational therapy practice act. They are responsible for protecting the public in that state from potential harm caused by incompetence or unqualified practitioners. Only those states with licensure, registration, or certification laws have regulatory boards to enforce the law. SRBs have the authority, by state law, to discipline members who are licensed occupational therapists and occupational therapy assistants. They have the legal authority to conduct investigations, including subpoena of witnesses, as well as imposing fines or recommending imprisonment. When a state regulatory board determines that an individual has violated the law, the board can mandate one or more sanctions as a disciplinary measure. Some examples of disciplinary actions include public censure, temporary or permanent suspension of a license to practice in that state, probationary license with conditions, and monetary fine.

Disciplinary Action in Healthcare Professions

Although healthcare professionals are viewed as being trusted and ethical professionals, there are still a small group of healthcare providers that are the subject of disciplinary actions by their respective regulatory boards. A brief review of the literature is discussed for this study.

The National Council of State Boards of Nursing conducted a review of disciplinary action data for nurses from 1996-2006 (Kenward, 2008). The report analyzed disciplinary data reported by forty-four boards of nursing. Some of the conclusions of the study indicated that a very small percentage (less than 1%) of nurses are disciplined in any given year; practical nurses are more likely to be disciplined than registered nurses or advanced practice registered nurses; drug related violations represent 24% of all violations; males are disproportionately disciplined

especially among nurses with a chemical dependency problem; almost 96% of disciplined nurses have been disciplined in only one state; discipline occurs less frequently among nurses with one year or less or experience, and 39% of disciplined nurses have been licensed between ten and twenty-four years; and one-fifth (21%) of disciplined nurses recidivate (Kenward, 2008).

Strom-Gottfried (2000) conducted a study to examine ethics complaints filed with the National Association of Social Workers (NASW) from 1986-1997. This was a review for ten years preceding NASW's revised Code of Ethics. The author examined 894 ethics cases filed with NASW. NASW can only adjudicate complaints against its members, which represent only a portion of practicing social workers. NASW does not receive the volume of complaints addressed by licensure or regulatory boards, and the number of complaints and cases in which there were violations represent a small percentage of all the social workers and professional transactions that take place yearly (Strom-Gottfried, 2000, p. 258). The findings report indicated areas for concern and attention. Sexual improprieties and other boundary transgressions (55%) were of serious concerns (Strom-Gottfried, 2000). The second most common form of violation was poor practice. There were few confidentiality violations, only 14.2 % of the cases (Strom-Gottfried, 2000). The study did not attempt to detail the behaviors that were the subject of allegations, only those in which there were findings. The article concluded with suggestions for reducing the risk of ethics complaints and enhancing quality practice for social workers.

Papadakis et al. (2005) studied disciplinary actions taken by medical boards. Disciplinary action against physicians and their prior behavior in medical school was examined. Graduates of three medical programs who were disciplined between 1990 and 2003 determined that disciplinary action had a strong correlation with prior unprofessional behavior in medical school. Papadakis, Arnold, Blank, Holmboe and Lipner (2008) further studied internal medicine

residents with low professionalism scores in their residency were more likely to be disciplined later as practicing physicians.

Physical therapy recently conducted a study looking at disciplinary reports and actions taken by licensing boards during 2000-2009 (Ingram, Mohr, Walker and Mabey, 2013). Their data were obtained from the Federation of State Boards of Physical Therapy. The database was from forty-nine of the fifty-three jurisdictions. Individual disciplinary data were not examined and only aggregate data was provided. The authors found that less than 1% of licensed physical therapists were disciplined. The most common offenses were related to failure to comply with statutory requirements. Other findings from the study indicated that males were disciplined more frequently than females, and non-U.S. educated physical therapists and male physical therapists were disciplined for more flagrant offenses than expected (Ingram, et al., 2013).

Disciplinary Actions in Tennessee and Alabama for Occupational Therapy Professionals

When comparing Tennessee and Alabama practice acts the following were found regarding disciplinary actions that could be taken by each licensing board. The Code of Alabama – Alabama State Occupational Therapy Practice Act in Section 34-39-12 states:

> the board, shall after taking notice and opportunity for hearing, have the power to deny or refuse to renew a license, or may suspend or revoke a license, or may impose probationary conditions, where the licensee or applicant for license has been guilty of unprofessional conduct which has endangered or is likely to endanger the health, welfare, or safety of the public. (Alabama State Board of Occupational Therapy Alabama State Occupational Therapy Practice Act (Alabama State Board of Occupational Therapy, 2013a. Acts 1990, No. 90-383, p. 515, §12.)

And Alabama's rules regarding Sanctions in section 625-X-9-.03 Sanctions states:

> (1) After a hearing as provided under §34-39-12, the Board may, in its discretion, revoke or suspend a license for such period of time as the Board believes to be warranted by the facts and evidence presented.

(2) The Board may, in lieu of revoking or suspending a license, place the licensee on probation for a period not to exceed one year, except that if the adjudication of the violation is the second such adjudication within five years, the licensee shall not be entitled to probation. (Alabama State Board of Occupational Therapy Rules and Regulations Administrative Code 2013a,Chapter 625-X-9-.03)

Tennessee's Licensure law Disciplinary Actions, Civil Penalties, and Screening Panels in Section 1150-02.15 states:

(1) Upon a finding by the Board that a [sic] occupational therapist or occupational therapy assistant has violated any provision of the Tennessee Code Annotated §§63-13-101, et seq. or the rules promulgated thereto, the Board may impose any of the following actions separately or in any combination deemed appropriate to the offense:

(a) Advisory Censure - This is a written action issued to the occupational therapist or occupational therapy assistant for minor or near infractions. It is informal and advisory in nature and does not constitute a formal disciplinary action.

(b) Formal Censure or Reprimand - This is a written action issued to an occupational therapist or occupational therapy assistant for one time and less severe violations. It is a formal disciplinary action.

(c) Probation - This is a formal disciplinary action which places an occupational therapist or occupational therapy assistant on close scrutiny for a fixed period of time. This action may be combined with conditions which must be met before probation will be lifted and/or which restricts the individual's activities during the probationary period.

(d) Licensure Suspension - This is a formal disciplinary action which suspends an individual's right to practice for a fixed period of time. It contemplates the reentry of the individual into the practice under the license previously issued.

(e) Licensure Revocation - This is the most severe form of disciplinary action which removes an individual from the practice of the profession and terminates the license previously issued. If revoked, it relegates the violator to the status he possessed prior to application for licensure. However, the Board may, in its discretion allow the reinstatement of a revoked license upon conditions and after a period of time it deems appropriate. No petition for reinstatement and no new application for licensure from a person whose license was revoked shall be considered prior to the expiration of at least one (1) year unless otherwise stated in the Board's revocation order. (p.39)

The Tennessee State Board of Occupational Therapy can also impose civil penalties ranging from a Type A Civil Penalty to a Type C Civil Penalty as a disciplinary action (Tennessee Board of Occupational Therapy General Rules Governing the Practice of Occupational Therapy, 2012, p.44).

The profession of occupational therapy protects both the public and its practitioners by developing and enforcing its core values through the Code and Ethics Standards. Three primary organizations have ethical oversight of the occupational therapy profession. In some cases, their jurisdiction may overlap, but each focuses on particular areas of ethical behavior and has procedures for enforcing appropriate professional conduct. Occupational therapists and occupational therapy assistants have a responsibility to be aware of and comply with the policies and procedures of these organizations. This research examined the disciplinary reports taken by two states, Tennessee and Alabama, in which one state, Tennessee, required mandatory ethics and jurisprudence training and another state, Alabama, did not require mandatory ethics and jurisprudence training.

This study also examined if there was a difference in the percentage of disciplinary reports for occupational therapy professionals licensed in Tennessee who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals in Tennessee prior to mandated ethics and jurisprudence training. This investigation examined if the difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee that received mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners licensed in Alabama that did not receive mandatory ethics and jurisprudence training.

CHAPTER III

METHODOLOGY OF THE STUDY

This research used secondary data that was publicly available through the Tennessee State Board of Occupational Therapy and the Alabama State Board of Occupational Therapy. The occupational therapy regulatory boards had previously collected the data. The researcher had no involvement in the data collection effort. McMillan and Schumacher (2010) present several considerations for using secondary data. This author considered all these factors. The dataset should contain variables that allow the research questions to be answered. The data were collected from the population of interest (occupational therapists and occupational therapy assistants). The data were available for a four-year period prior to the implementation of mandatory ethics and jurisprudence training in Tennessee and five years after the implementation. Alabama had the data available for that same nine-year period. There were adequate data to complete statistical analyses. In Tennessee the data were available to the general public through the State of Tennessee's webpage. Alabama data were available by contacting the Alabama State Board of Occupational Therapy. The dataset for both states contained data within a similar structure. The demographics and offenses/violations were similarly coded. Both states used similar codes for reprimands/disciplinary actions of ethical violations based on the American Occupational Therapy Code of Ethics. Finally, technical assistance was available for the dataset and its use. The researcher contacted both the Tennessee

State Board of Occupational Therapy and the Alabama State Board of Occupational Therapy. Both regulatory boards were aware that the data were utilized for this study.

This research study utilized a quantitative approach to analyzing the data. The following data were collected (when available for each subject):

- State or jurisdiction
- Gender
- Age at the time of the disciplinary action (Alabama only)
- Years since graduation from OT program
- Year of disciplinary action
- Location of training (United States or outside of the United States)
- Number of reported offenses
- Type of violation(s)
- Type of disciplinary action(s)

This study accessed archival data from both the Alabama and Tennessee Occupational Therapy Licensure Boards. All disciplinary reports are available to the public for inspection. The study examined these two states in order to compare disciplinary reports over the span of nine years (2004-2012). Tennessee's data included records for occupational therapy professionals prior to ethics and jurisprudence (E & J) training (2004-2007) and after mandatory ethics and jurisprudence training (2008-2012). Alabama's data incorporated all disciplinary reports over the same nine years in a state that does not mandate ethics and jurisprudence training. This inspection of disciplinary reports in two different states examined the potential impact of ethics and jurisprudence training for occupational therapy professionals in Tennessee.

Delimitations of the Study

This study examined only data from Alabama and Tennessee licensing boards to compare the differences in disciplinary reports between two comparable states that exhibit regional similarities. The study did not examine data older than 2004 since the data were not available

publically in Tennessee. Reviewing four years prior to the mandated ethics and jurisprudence training provided an adequate picture of disciplinary actions taken by the licensure board in Tennessee. This study only examined licensed occupational therapy professionals in Alabama and Tennessee and did not review any other healthcare professions in relation to mandatory ethics and jurisprudence training. The author is an occupational therapist and was interested in results specific to the profession of occupational therapy.

Limitations of the Study

There were several limitations to this study. One significant limitation was the availability of information that was accessible to the researcher. Alabama and Tennessee Occupational Therapy Licensure Boards disciplinary reports are public information, but the information provided to the public varies. For example, in Tennessee the information was found on their website by reviewing minutes of the Board meetings (Tennessee Board of Occupational Therapy, 2013) and by reviewing disciplinary action reports for all occupational therapists and occupational therapy assistants in Tennessee (Tennessee Department of Health, 2013). In Alabama the Executive Director of the Alabama State Licensure Board, Ann Cosby, had to be contacted to obtain the information on disciplinary actions. This information is public, but is not available on the Alabama State Board of Occupational Therapy website. Each state board can choose the information to provide to the public and to whom the information will be made available. The Disciplinary Action Information Exchange Network (DAIEN) contains final disciplinary actions and non-disciplinary actions taken by National Board for Certification in Occupational Therapy (NBCOT), as well as disciplinary actions taken by state regulatory entities. Actions are posted to the DAIEN on a quarterly basis and removed after one year.

NBCOT encourages all state regulatory entities to submit their disciplinary actions to the DAIEN, but reporting the penalty is not mandatory. The DAIEN produces a quarterly report of all jurisdictions that have reported disciplinary actions on their website (NBCOT, 2013). This study did not have an instrument but did collect information that is publicly available (court documents of disciplinary actions, date of initial licensure in the state, etc.). The study population was limited to occupational therapists and occupational therapy assistants licensed to practice in the states of Alabama and Tennessee. While the codes of ethics for both states are similar, the state governing boards are bound by differing rules and regulations.

The study was limited by the short timeframe during which the data were collected. The data only spans nine years. Disciplinary actions may have occurred after the alleged violation; these cases sometimes have delays of months to years before disciplinary action is taken. Only one case was still open in Alabama that data were not included in this study. Tennessee occupational therapy professionals had been given a two-year notice prior to the enforcement of ethics and jurisprudence training. The researcher did not discover any indication that there were any unresolved cases prior to January 2008.

There were other factors that could have influenced this study. The accuracy of the data could have been affected by clerical errors. Tennessee and Alabama licensing boards could have been inconsistent in determining the categories of disciplinary actions. There could have been missing data that the author cannot verify. The researcher only utilized the data that were available at the time of this study.

Description of the Population

The total population was all occupational therapists and occupational therapy assistants in Alabama and Tennessee at the time of data collection. The data included those occupational therapy professionals that had been disciplined by both state boards of occupational therapy from 2004 – 2012. There were 151 disciplinary reports filed from 2004-2012 for both states. Alabama had 40 and Tennessee had 111. The total number of occupational therapy professionals in 2012 for Tennessee was 3200 and in Alabama there were 1889. The numbers of disciplinary actions expected were few (Ingram, et al., 2013).

Procedures

Licensure boards in Tennessee and Alabama are responsible for safeguarding the health, safety, and welfare of their citizens by requiring that all who practice occupational therapy in the state to be qualified. These boards provide public information regarding disciplinary actions of occupational therapy practitioners in their respective states. This study included the disciplinary reports that were undertaken by the licensing boards in Alabama and Tennessee from 2004-2012. The data collected for each state included if the therapist was either an occupational therapist or occupational therapy assistant, gender, age at the time of the disciplinary action (Alabama only), years since graduation from an occupational therapy program, year of disciplinary report, whether they were educated in the United States or foreign trained, number and type of reported offenses, and number and type of disciplinary actions.

The dataset for Tennessee were collected from the website for the Tennessee State Board of Occupational Therapy and the State Board of Health Professions (Tennessee Department of Health, 2013). The Executive Director, Ann Cosby, was contacted at the Alabama State Board

of Occupational Therapy (2013c) to collect the dataset for Alabama. The researcher collected the data for Alabama during a visit to the Alabama State Board of Occupational Therapy's office in Montgomery, Alabama.

Coding

All disciplinary reports were read and coded with descriptors of the occupational therapy professionals gender, education (U.S. or foreign trained), date of initial certification as an occupational therapy practitioner, date of birth (only available for Alabama), type and frequency of offenses the therapist had been charged, type and frequency of disciplinary actions ordered by the regulatory boards. The time between license violation and action was computed by the year the disciplinary report was decreed.

The level of the occupational therapy professional was coded as occupational therapist or occupational therapy assistant. The information available did not provide enough contextual information about the type of occupational therapy practice. Practice areas were not included in this study.

The Tennessee State Practice Act was used as the guide to code both the offenses and the disciplinary actions. The Practice Act clearly defines eighteen different types of offenses that a Tennessee occupational therapist or occupational therapy assistant could be charged. The Board Orders clearly stated which offenses the therapist had committed. Alabama offenses were not as clear. The researcher coded Alabama offenses and actions in the same categories that were used by Tennessee State Practice Act.

Offenses were coded according to the Tennessee Occupational Therapy Practice Act Section T.C.A. § 63-13-209, Denial, Suspension or Revocation of License (Tennessee Code, 2013).

> The board of occupational therapy has the power, and it is its duty to deny, suspend or revoke the license of, or to otherwise lawfully discipline, a licensee whenever the licensee is guilty of violating any of the provisions of this part or is guilty of any of the following acts or offenses:
>
> (1) Unprofessional, dishonorable or unethical conduct;
>
> (2) Violation or attempted violation, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part or any lawful order of the board issued pursuant thereto, or any criminal statute of the state of Tennessee;
>
> (3) Making false or misleading statements or representations, being guilty of fraud or deceit in obtaining admission to practice, or being guilty of fraud or deceit in the licensee's practice;
>
> (4) Gross malpractice, or a pattern of continued or repeated malpractice, ignorance, negligence or incompetence in the course of professional practice;
>
> (5) Habitual intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances or other drugs or stimulants in such a manner as to adversely affect the person's ability to practice;
>
> (6) Conviction of a felony, conviction of any offense under state or federal drug laws, or conviction of any offense involving moral turpitude;
>
> (7) Making or signing in one's professional capacity any certificate that is known to be false at the time one makes or signs such certificate;
>
> (8) Engaging in practice when mentally or physically unable to safely do so;
>
> (9) Solicitation by agents or persons generally known as "cappers" or "steerers" of professional patronage or profiting by the acts of those representing themselves to be agents of the licensee;
>
> (10) Division of fees or agreeing to split or divide fees received for professional services with any person for bringing or referring a patient;
>
> (11) Conducting practice so as to permit, directly or indirectly, an unlicensed person to perform services or work that, under the provisions of this part, can be done legally only by persons licensed to practice;
>
> (12) *This offense number was used for failure to complete continuing education*

requirements. This following offense was never recorded as an offense by either Tennessee or Alabama occupational therapists. Professional connection or association with any person, firm or corporation in any manner in an effort to avoid and circumvent the provisions of this part, or lending one's name to another for illegal practice;

(13) Payment or acceptance of commissions, in any form or manner on fees for professional services, references, consultations, pathological reports, prescriptions or on other services or articles supplied to patients;

(14) Giving of testimonials, directly or indirectly, concerning the supposed virtue of secret therapeutic agents or proprietary preparations, such as remedies, or other articles or materials that are offered to the public, claiming radical cure or prevention of diseases by their use;

(15) Violating the code of ethics adopted by the board;

(16) Any other unprofessional or unethical conduct that may be specified by the rules duly published and promulgated by the board, or the violation of any provision of this part (this was coded for failure to pay student loans);

(17) On behalf of the licensee, the licensee's partner, associate, or any other person affiliated with the licensee or the licensee's facility, use or participate in the use of any form of public communication containing a false, fraudulent, misleading or deceptive statement or claim; or

(18) Disciplinary action against a person licensed to practice occupational therapy by another state or territory of the United States for any acts or omissions that would constitute grounds for discipline of a person licensed in this state. A certified copy of the initial or final order or other equivalent document memorializing the disciplinary action from the disciplining state or territory shall constitute prima facie evidence of violation of this section and be sufficient grounds upon which to deny, restrict or condition licensure or renewal and/or discipline a person licensed in this state.

Both Alabama and Tennessee had the same disciplinary actions in their Practice Acts that were available for sanctions. Disciplinary actions for Tennessee and Alabama were coded according to the Tennessee's Licensure law Disciplinary Actions, Civil Penalties, and Screening Panels in Section 1150-02.15.

(1) Upon a finding by the Board that a [sic] occupational therapist or occupational therapy assistant has violated any provision of the Tennessee Code Annotated §§63-13-101, et seq. or the rules promulgated thereto, the Board may impose any of the following actions separately or in any combination deemed appropriate to the offense:

- Advisory Censure – This is a written action issued to the occupational therapist or occupational therapy assistant for minor or near infractions. It is informal and advisory in nature and does not constitute a formal disciplinary action.
- Formal Censure or Reprimand - This is a written action issued to an occupational therapist or occupational therapy assistant for one time and less severe violations. It is a formal disciplinary action.
- Probation - This is a formal disciplinary action which places an occupational therapist or occupational therapy assistant on close scrutiny for a fixed period of time. This action may be combined with conditions which must be met before probation will be lifted and/or which restricts the individual's activities during the probationary period.
- Licensure Suspension - This is a formal disciplinary action which suspends an individual's right to practice for a fixed period of time. It contemplates the reentry of the individual into the practice under the license previously issued.
- Licensure Revocation - This is the most severe form of disciplinary action which removes an individual from the practice of the profession and terminates the license previously issued. If revoked, it relegates the violator to the status he possessed prior to application for licensure. However, the Board may, in its discretion allow the reinstatement of a revoked license upon conditions and after a period of time it deems appropriate. No petition for reinstatement and no new application for licensure from a person whose license was revoked shall be considered prior to the expiration of at least one (1) year unless otherwise stated in the Board's revocation order. (p.39)

Data Analysis

The research utilized nonparametric methods of quantitative research. The statistical procedure was the Chi-square. Chi-square is a common nonparametric procedure that is used when the data is in nominal form. It is a quantitative measure used to determine whether a relationship exists between two categorical variables. The chi-square statistic measures the difference between the expected and observed frequencies and is thus a quantitative measure of this relationship. It is used when the data consist of nominal data (people - occupational therapists and/or occupational therapy assistants) distributed across categories (age, gender, disciplinary reports before or after mandatory ethics and jurisprudence training, etc.) and seeks to

identify whether the distribution is different from what would be expected by chance (or another set of expectations). Chi-square can be used to test whether the observed data conform (or are statistically different) to some theoretical or expected distribution or to see if two variables within a sample are related or if two or more samples, drawn from different populations, are homogenous on some characteristic of interest. The null hypothesis is that there is no difference between these distributions of major selections from what would be expected by chance. Chi-square compared these numbers (the observed frequencies) with those that would be expected by chance (the expected frequencies).

The demographics data were analyzed using SPSS 20.0 in contingency tables (crosstabs). A contingency table looks at whether the value of one variable is associated with or contingent upon that of another. Usually these variables are nominal or ordinal. A two-way contingency table analysis was conducted to evaluate the length of time between certification and discipline, age of Alabama occupational therapy practitioner when disciplined, males and females that were disciplined, and the frequency of disciplinary offenses and actions that were taken by each state.

Institutional Review Board Approval

Before data collection began, Institutional Review Board (IRB) approval from the University of Tennessee at Chattanooga (UTC) was sought. Based on established guidelines at UTC, IRB was applied for and received. No data were collected until IRB approval had been obtained. Approval from the IRB and supporting documents can be found in Appendix A and Appendix B.

Summary

This chapter provided an outline for the research study methodology. The design of the study and the research questions guiding it were reviewed. A brief explanation of the process was included. The population was described. A description of the data collection was described. Data collection procedures and coding were discussed and finally, the methodology associated with data collection was described with an overview of data analysis.

This descriptive study synthesizes information about licensed occupational therapists and occupational therapy assistants in Alabama and Tennessee disciplined by their state regulatory boards from 2004-2012. Information was gathered about occupational therapy professionals, the types of unprofessional conduct found by the regulatory boards, and the types of disciplines that the boards imposed. The study provides a view of occupational therapy practitioners unprofessional practices in Tennessee both prior to and after mandatory ethics and jurisprudence training and the difference between Alabama occupational therapists and occupational therapy assistants that did not have mandatory ethics and jurisprudence training.

CHAPTER IV

RESULTS

This chapter is organized in terms of data collected and data generated from statistical analyses to substantiate the established research questions. The chapter concludes with the analyses of the collected data relating to the study's research questions.

Descriptive statistics were generated to determine what factors and characteristics (e.g., occupational therapist, occupational therapy assistant, years of certification prior to discipline, frequency and types of offenses and disciplinary actions) are related to disciplinary actions taken by the Alabama and Tennessee boards of occupational therapy. The purpose of this study was to determine whether the mandated ethics and jurisprudence training resulted in a decrease in disciplinary reports and subsequent actions taken by the Tennessee State Board of Occupational Therapy and then compared to the frequency of disciplinary reports from the Alabama State Board of Occupational Therapy for the same time period.

Data Collection

As discussed previously, the data collected were retrieved from existing databases. The data for Tennessee occupational therapy professionals were acquired from the Tennessee State Department of Health websites. The website for the Board of Occupational Therapy provided meeting minutes that included information on whom was disciplined and what sanctions were taken for that individual. This website also provided a link to practitioner profiles of all

healthcare professionals in Tennessee. The practitioner profiles provided information for all occupational therapy professionals in Tennessee including demographic information, such as, license number, occupational therapy school attended, and graduation date. The profiles included adverse licensure action reports. These adverse licensure action reports included the disciplinary offenses, the specific disciplinary action(s), and the effective date of the Board Order. The Executive Director, Ann Cosby, was contacted at the Alabama State Board of Occupational Therapy (2013c) to collect the dataset for Alabama. The researcher collected the data from the Alabama State Licensure Board in Montgomery, Alabama. The Executive Director of the Board made the disciplinary reports available to the researcher.

Demographic Data

The study population included all occupational therapists and occupational therapy assistants in the states of Alabama and Tennessee including those that had been disciplined from January 2004-December 2012. There were 151 disciplinary reports filed during this time period for both states. The majority of the reports were from Tennessee (111 reports, 74 %). Alabama had 40 disciplinary reports or 26 %. The total number of occupational therapy professionals in 2012 for Tennessee was 3200 and in Alabama there were 1889. The frequency of occupational therapists and occupational therapy assistants that were sanctioned in Alabama and Tennessee and their corresponding percentages are presented in Table 4.1.

Table 4.1 Frequency and Percentage of Disciplinary Reports for Occupational Therapy Professionals in Alabama and Tennessee (OT & OTA's) 2004-2012

	OT N	OT %	OTA N	OTA %	TOTAL N	TOTAL %
Alabama	25	62.5	15	37.5	40	26
Tennessee	66	59.5	45	40.5	111	74
TOTAL	91		60		151	

In Alabama there were 25 occupational therapists (62.5%) and 15 occupational therapy assistants (37.5%) that were disciplined. In Tennessee there were 66 occupational therapists (59.5%) and 45 occupational therapy assistants (40.5%). The combined total for both states were occupational therapists 91 (60.3%) and occupational therapy assistants 60 (39.7%). The percentage of licensed occupational therapists to occupational therapy assistants in 2012 in Alabama was 1239 occupational therapists (66%) and 650 occupational therapy assistants (34%). In Tennessee there were 2109 (66%) licensed occupational therapists in 2012 and 1091 occupational therapy assistants (34%). Based on these percentages of occupational therapists (66%) and occupational therapy assistants (34%) for both states, the frequency of disciplinary reports should be expected to be distributed similarly for occupational therapists and occupational therapy assistants. The percentages of disciplined occupational therapists were lower than the populations for occupational therapists in both Alabama (62.5%) and Tennessee (59.5%) and higher for occupational therapy assistants (Alabama 37.5%, Tennessee, 40.5%). Based on 2010 survey results from state regulatory boards, the American Occupational Therapy Association (AOTA) estimated the active occupational therapy workforce to be roughly 137,000 practitioners. This included approximately 102,500 or 75% occupational therapists and 34,500 or 25% occupational therapy assistants (AOTA, 2013). The percentages of disciplinary reports in Alabama and Tennessee were also lower than the national percentages for occupational

therapists (75% vs. AL 62.5% and TN 59.5%) and higher for occupational therapy assistants (25% vs. AL 37.5% and TN 40.5%).

There were 151 occupational therapy professionals that were disciplined in both Alabama and Tennessee from 2004-2012. There were 34 males (22.5%) and 117 females (77.5%) disciplined from both states during this time period (Table 4.2). There were no data to compare the total numbers of licensed occupational therapy professional males and females in Alabama and Tennessee. A 2010 AOTA survey indicated that 92% of occupational therapy practitioners were female and 8% were male (AOTA, 2013). The frequency of disciplinary reports for combined for occupational therapy professionals in Alabama and Tennessee males have a higher occurrence (22.5%) than the percentage of the general population of male occupational therapy practitioners (8%), according to a 2010 AOTA survey (AOTA, 2013).

Table 4.2 Frequency and Percentage of Disciplinary Reports by Gender for Occupational Therapy Professionals in AL and TN 2004-2012

	Frequency	Percent
Male	34	22.5
Female	117	77.5

Table 4.3 shows the frequency of male and female occupational therapists and occupational therapy assistants disciplined in Alabama and Tennessee by gender from 2004-2012. These frequencies are lower than a 2010 AOTA estimate of the occupational therapy practitioner workforce of occupational therapist's at 75% and occupational therapy assistants at 25%.

Table 4.3 Frequency of Disciplinary Reports for Occupational Therapists and Occupational Therapy Assistants by Gender in Alabama and Tennessee 2004-2012

	OT N %	OTA N %	TOTAL N %
Male AL	5 = 62.5%	3 = 37.5%	8= 20 %
Male TN	12 = 18.2%	14= 31.1%	26 = 23.4%
Female AL	20 – 62.5%	12 = 37.5%	32 = 80%
Female TN	54 = 81.8%	31 = 68.9%	85 = 76.6%
Total	91 = 60%	60 = 40%	151

Tennessee OT/OTA Male/Female x^2 (1,N=111), =2.494 p= .114
Alabama OT/OTA Male/Female unable to compute due less than 5 male OTA's

Data were collected during this nine- year time frame reviewing occupational therapy professionals that had been educated in the United States or foreign trained for both Alabama and Tennessee. There were only 3 foreign trained occupational therapists of the total 151 reported cases of disciplined therapists. All of the three foreign trained occupational therapists were licensed in Tennessee. There were no foreign trained occupational therapy assistants. Thus, a formal analysis was not conducted due to low cell frequency.

The years between initial licensure for occupational therapy professional and being disciplined was examined. The frequency and percentage of years between initial licensure and disciplinary action for occupational therapy professionals in Alabama and Tennessee are shown in Table 4.4. The largest number of years of practice at the time of discipline was 49 and the least number of years of practice was 0 (several months).

Table 4.4 Frequency and Percentage of Years Between Initial Licensure and Disciplinary Action for Occupational Therapy Professionals in Alabama and Tennessee

Years Licensed Before Disciplined	AL N	AL % in State	TN N	TN % in State	AL & TN Total N	Total % AL & TN
0	0	.0	2	1.8	2	1.3
1	3	7.5	3	2.7	6	4.0
2	1	2.5	0	.0	1	0.7
3	2	5.0	1	0.9	3	2.0
5	0	.0	7	6.3	7	4.6
6	1	2.5	6	5.4	7	4.6
7	4	10.0	3	2.7	7	4.6
8	2	5.0	5	4.5	7	4.6
9	1	2.5	4	3.6	5	3.3
10	3	7.5	7	6.3	10	6.6
11	3	7.5	6	5.4	9	6.0
12	3	7.5	6	5.4	9	6.0
13	4	10.0	10	9.0	14	9.3
14	0	.0	6	5.4	6	4.0
15	2	5.0	6	5.4	8	5.3
16	3	7.5	6	5.4	9	6.0
17	0	.0	2	1.8	2	1.8
18	0	.0	8	7.2	8	5.3
19	0	.0	1	0.9	1	0.7
20	1	2.5	2	1.8	3	2.0
21	1	2.5	5	4.5	6	4.0
22	1	2.5	1	0.9	2	1.3
23	1	2.5	4	3.6	5	3.3
24	1	2.5	0	.0	1	0.7
25	0	.0	4	3.6	4	2.6
26	1	2.5	0	.0	1	0.7
27	0	.0	1	0.9	1	0.7
28	0	.0	1	0.9	1	0.7
29	1	2.5	0	.0	1	0.7
30	0	.0	1	0.9	1	0.7
32	0	.0	1	0.9	1	0.7
33	0	.0	1	0.9	1	0.7
37	0	.0	1	0.9	1	0.7
49	1	2.5	0	.0	1	0.7
TOTAL	40	100	111	100	151	100

Table 4.5 illustrates the three most prevalent years of practice when disciplined. When examining the data for both states the most frequently reported years of experience at the time of the disciplinary action was year 13 with a total of 14 disciplinary reports for both states. This number accounted for 9.3% of all Tennessee's disciplinary reports and 10% in Alabama. The second most frequent occurring number of years between initial licensure and disciplinary reports in Tennessee was 18 years for 7.2% of the total. Alabama's second most frequent was 1, 10, 11, 12, and 16 years at 3 occurrences per year each accounting for 7.5% of the total. Finally, the third most frequent years of initial license and time of discipline for Tennessee was 5 and 10 years, each with 7 occurrences per year accounting for 6.3% of Tennessee's total. Alabama's third most prevalent was 3, 8, and 15 years with 2 occurrences per year accounting for 5% of the total per year.

Table 4.5 Years between Initial Licensure and Disciplinary Reports for Occupational Therapy Professionals in Alabama and Tennessee: Top 3 Most Prevalent Years

State	Alabama (N) %	Tennessee (N) %
Most Prevalent	13 years (4) 10% 4 years (4) 10%	13 years (10) 9.0%
Second Most Prevalent	1 year (3) 7.5% 10 years (3) 7.5% 11 years (3) 7.5% 12 years (3) 7.5% 16 years (3) 7.5%	18 years (8) 7.2%
Third Most Prevalent	3 years (2) 5.0% 8 years (2) 5.0% 15 years (2) 5.0%	5 years (7) 6.3% 10 years (7) 6.3%

The age the therapist was disciplined was only analyzed for Alabama. The dataset from the Alabama State Board of Occupational Therapy included each therapist's birthdates. This information was not available for Tennessee occupational therapy practitioners. See Figure 4.2

for Age when Disciplined for Alabama Occupational Therapy Professionals. The mean age was 41.35, the median and the mode for the most frequent age was 42 with 4 cases.

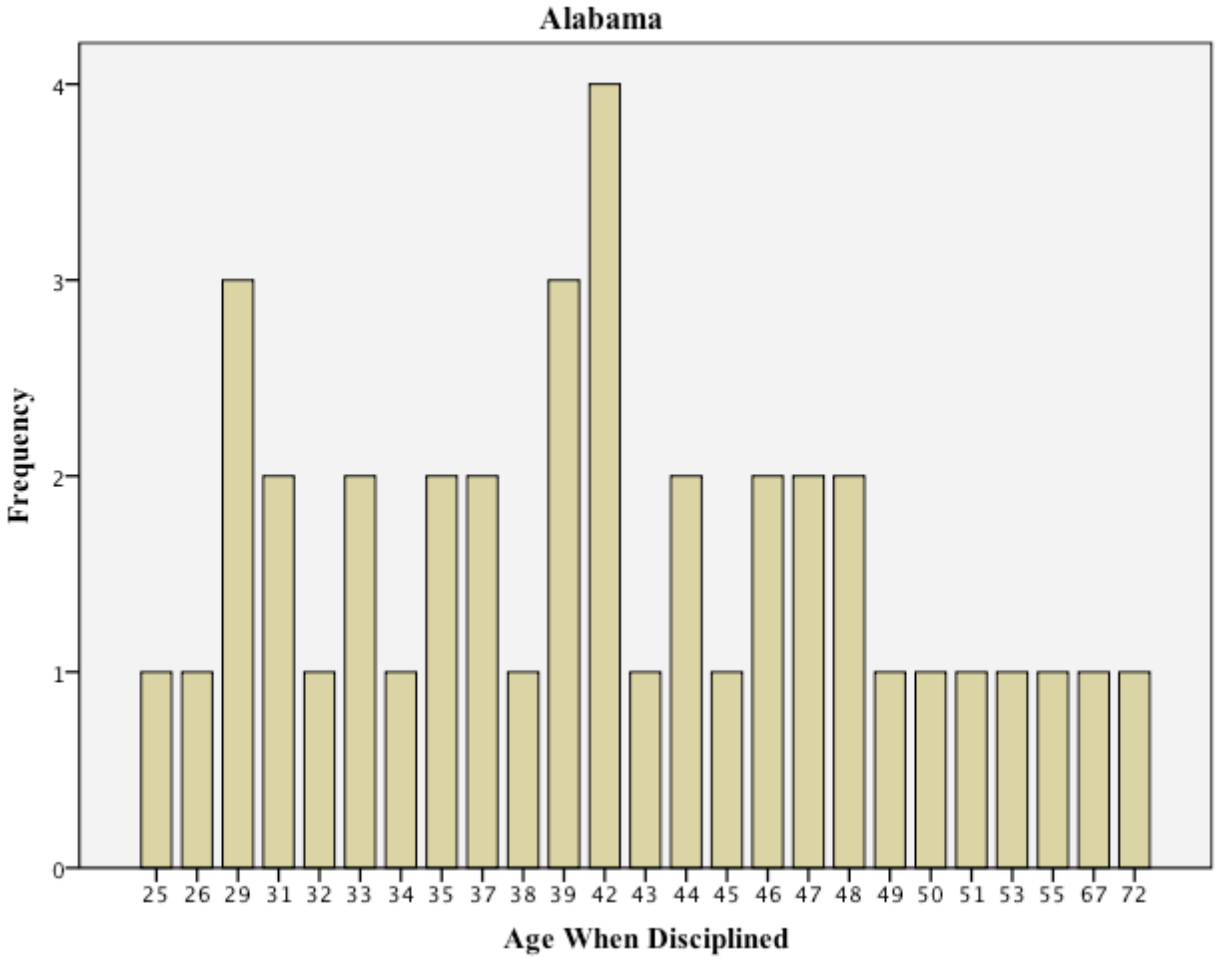


Figure 4.1 Age When Disciplined in Alabama (2004 – 2012)

The total number of licensed therapists for each state was collected for the years January 2004- December 2012 from each state. There are more occupational therapy professionals licensed in Tennessee than Alabama. For instance in the year 2012 Alabama had a total of 1889 occupational therapy practitioners and Tennessee had a total of 3200 (see Table 4.6). In Alabama there were 4 schools for occupational therapists and one for occupational therapy

assistants during the time of this data collection. In Tennessee there were 4 occupational therapy schools and 2 occupational therapy assistant schools.

Table 4.6 Number of Licensed Occupational Therapy Professionals in Alabama and Tennessee 2004-2012

State	2004	2005	2006	2007	2008	2009	2010	2011	2012
Alabama	1322	1372	1410	1499	1587	1631	1706	1810	1889
Tennessee	2246	2346	2432	2554	2634	2764	2921	3086	3200

When discussing the number of disciplinary reports for occupational therapy professionals in both Alabama and Tennessee it is important to keep the numbers in context. Table 4.7 displays the incidence of disciplinary reports based on the number of licensed occupational therapy professionals for each year. Both states reported the incidence of disciplinary reports were less than one percentage with the exception of Tennessee with 1.555% in 2009.

Table 4.7 Incidence of Disciplinary Reports by Year, Based on the Number of Licensed Occupational Therapy Professionals in Alabama and Tennessee

Year	Licensed OT's Alabama N	Licensed OT's Tennessee N	Reports Alabama N	Reports Tennessee N	Incidence Alabama %	Incidence Tennessee %
2004	1322	2246	3	2	.227	.089
2005	1372	2346	1	1	.073	.043
2006	1410	2432	6	0	.425	.000
2007	1499	2554	4	3	.267	.082
2008	1587	2634	5	1	.315	.038
2009	1631	2764	4	43	.246	1.555
2010	1706	2921	8	15	.469	.514
2011	1810	3086	5	28	.277	.910
2012	1889	3200	4	18	.211	.563
TOTAL			40	111		

Research Questions and Data Analysis

The research questions directing this study were:

Research Question One: Is there a difference in the percentage of disciplinary reports for occupational therapy professionals licensed in Tennessee who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners in Tennessee prior to mandated ethics and jurisprudence training?

Research Question Two: Is there a difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals licensed in Alabama who did not participate in mandatory ethics and jurisprudence training?

Data Relating to Research Question One

Data were analyzed to determine the answer to question number one: Is there a difference in the percentage of disciplinary reports for occupational therapy professionals licensed in Tennessee who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners in Tennessee prior to mandated ethics and jurisprudence training? Table 4.8 illustrates the number and percentage of disciplinary reports taken from year's 2004- 2012.

Table 4.8 Year, Frequency and Percentage of Disciplinary Reports Taken against Occupational Therapy Professionals In Tennessee 2004-2012

Year of Discipline TN	Disciplinary Reports TN N	Disciplinary Reports TN %
2004	2	1.8
2005	1	0.9
2006	0	.0
2007	3	2.7
2008	1	0.9
2009	43	38.7
2010	15	13.5
2011	28	25.2
2012	18	16.2
TOTAL	111	100

Table 4.9 examines the number of occupational therapy professionals that were disciplined between the years 2004-2007 (before mandatory ethics and jurisprudence training) and the years 2008-2012 (years after mandatory ethics and jurisprudence). This indicates that Tennessee had a higher percentage (94.5%) of all disciplinary reports for the five-year period after ethics and jurisprudence training was made mandatory when compared to no training in years 2004-2007 (5.4%). A Chi-square analysis was conducted to assess if there was a difference in the percentage of occupational therapy professionals that participated in ethics and jurisprudence training and the number of disciplinary reports for Tennessee occupational therapy professionals for the years 2008-2012 and those occupational therapy practitioners that did not participate in ethics and jurisprudence training and the number of disciplinary reports for the years 2004-2007. The percentage of all occupational therapy professionals that were disciplined in Tennessee before (2004-2007) ethics and jurisprudence training was 0.2% and the percentage of all occupational therapy professionals disciplined after ethics and jurisprudence training was 3.3%. This difference was statistically significant x^2 (1,N=111), =69.672p < .001. The number

of occupational therapy professionals used to calculate this difference was based on the total number of occupational therapy practitioners licensed in the state in 2012, as reported by the Tennessee Occupational Therapy Licensure Board. This number may not be as accurate as possible due to practitioners retiring or newly licensed, however, it was determined that this would be the closest approximation of practitioners to compare the data.

Table 4.9 Frequency of Therapists Disciplined and Percentage of Disciplinary Reports taken before Mandatory E & J Training (2004-2007) and after Mandatory E & J Training (2008-2012)

Calendar Year	OT's Disciplined N	Therapists Disciplined %
2004-2007	6	5.4
2008-2012	105	94.5

In the years of 2004-2007 there were a total of 6 disciplinary reports (Figure 4.2). After the implementation of mandatory ethics and jurisprudence the incidence of disciplinary reports increased to a total of 105. Of all the disciplinary reports taken by the Tennessee State Board of Occupational Therapy from the years 2004-2012 the largest percentage (94.5%) of disciplinary reports occurred after the implementation of mandatory ethics and jurisprudence. This mandate also included the completion of required continued competence evidence. See the Tennessee Board of Occupational Therapy Policy Statement on Continued Competence (Appendix C) this policy was implemented in March 2009 to address the failure to comply with the requirement.

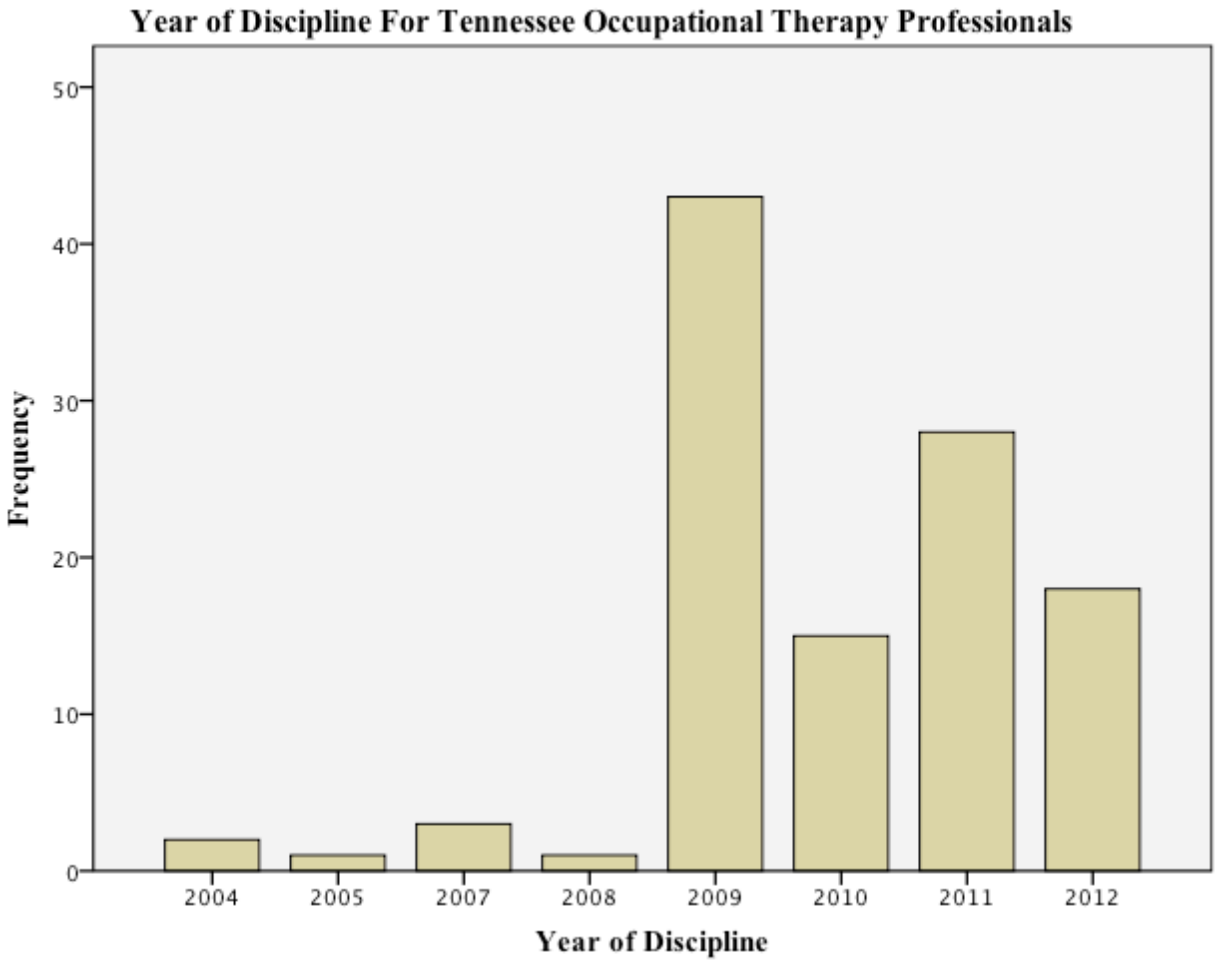


Figure 4.2 Year of Discipline for Tennessee Occupational Therapy Professionals

There was a significant increase in the number of disciplinary reports taken in 2009. This increase resulted from an audit of occupational therapy practitioners applying for renewal of their license and being audited for evidence of the newly implemented continuing competence requirement that became effective in January 2008. This was the first year the state completed an audit of license renewals to meet this requirement. There were 90 reported disciplinary reports between 2008 and 2012 for failure to complete continuing education requirements for licensure renewal.

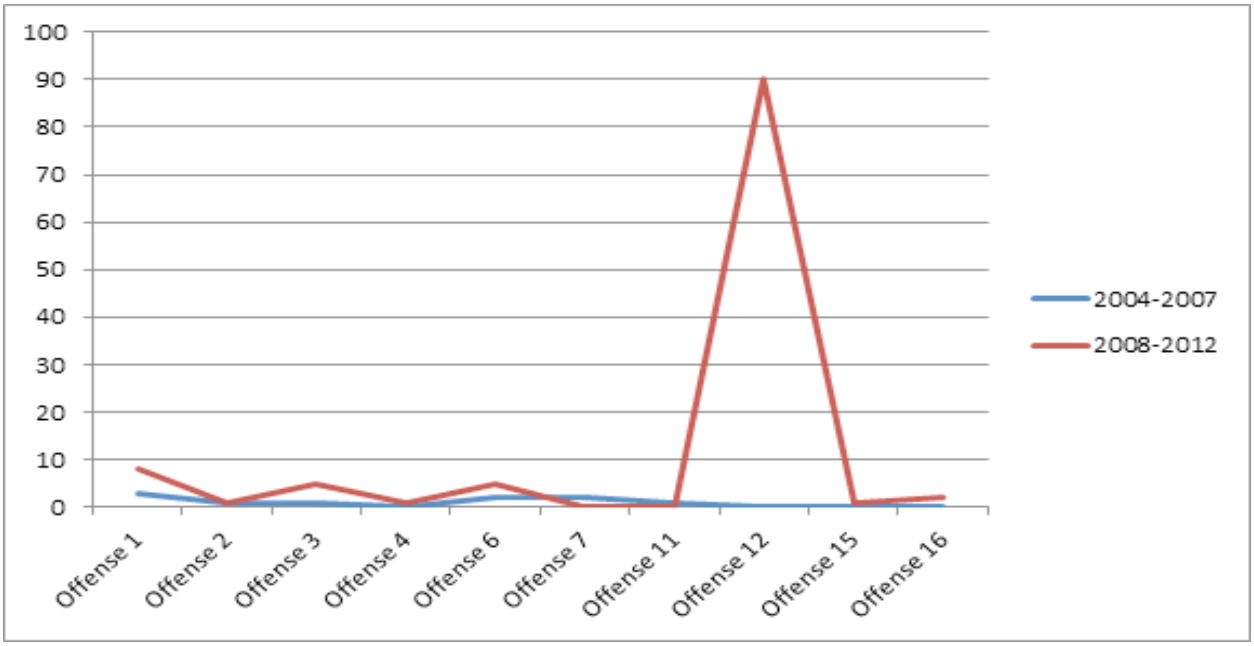
To assist in understanding why there was such a large increase in the number of disciplinary reports taken in Tennessee the types of offenses/violations that occupational therapy practitioners were charged with during this time period were analyzed. The specific offenses that were recorded by the Tennessee State Board of Occupational Therapy are shown in Table 4.10. These frequencies indicate the disciplinary offenses that were reported in Tennessee for occupational therapy professionals from 2004-2012. There are more offenses reported than disciplinary reports. Each occupational therapy practitioner may have been charged with violating more than one offense per disciplinary report.

Table 4.10 Date of Discipline and Offense for Tennessee Occupational Therapy Professionals 2004-2012

	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
Offense 1	1	1	0	1	0	3	2	3	0	11
Offense 2	0	1	0	0	0	0	0	0	1	2
Offense 3	1	0	0	0	0	1	1	3	0	6
Offense 4	0	0	0	0	0	0	1	0	0	1
Offense 6	0	0	0	2	1	1	2	1	0	7
Offense 7	1	0	0	1	0	2	0	1	0	5
Offense 11	1	0	0	0	0	0	0	0	0	1
Offense 12	NA	NA	NA	NA	0	39	12	23	16	90
Offense 15	0	0	0	0	0	0	1	0	0	1
Offense 16	0	0	0	0	0	0	0	1	1	2

*See Appendix D for a description of each Offense
* 2004-2007 There was no Offense 12 that could be reported (before mandate)

The frequency of reported offenses for Tennessee for years 2004-2007 and 2008-2012 are in Figure 4.3. Prior to mandatory ethics and jurisprudence training the most frequent offense was Offense 1 – Unprofessional, dishonorable or unethical conduct. The most reported offense after ethics and jurisprudence training was implemented was Offense 12 (failure to complete continuing competence) and this offense was not recorded prior to 2008.



- Each therapist may have been disciplined for more than one offense
- 2004-2007 There was no Offense 12 that could be reported (before mandate)

Figure 4.3 Frequency of Reported Offenses Tennessee 2004-2007 and 2008-2012

After reviewing the most frequently reported offenses in Tennessee it is important to examine the most frequently reported disciplinary actions for Tennessee. As is shown in Table 4.11 the number of reprimands before ethics and jurisprudence training and after ethics and jurisprudence training was exactly the same at two. There were more censures before the implementation of ethics and jurisprudence training at 2 to 0. There were more (5 to 1) probations sanctioned after ethics and jurisprudence training. There were more revocations (2 to

1) after ethics and jurisprudence training. The largest increase of disciplinary actions was in civil penalties. The Board consistently imposed a civil penalty as one of the sanctions against the occupational therapy practitioner that did not complete their continuing competence requirement for licensure renewal (See Appendix C for the Policy Statement on Continued Competence). Tennessee did not report any individuals they did not take any disciplinary action.

Table 4.11 Tennessee: Frequency of Disciplinary Actions by Year and Type

	2004-2007 N	2008-2012 N	Total N 2004-2012
Reprimand	2	2	4
Censure	2	0	2
Probation	1	5	6
Suspension	0	6	6
Revocation	1	2	3
Civil Penalty	2	90	92
No Action	0	0	0
TOTAL	8	105	113

* There were more disciplinary actions than therapists disciplined.

Figure 4.4 shows the significant increase in the disciplinary action of civil penalties in 2009. This was directly associated with the number of offenses in 2009 of failure to complete continuing competence.

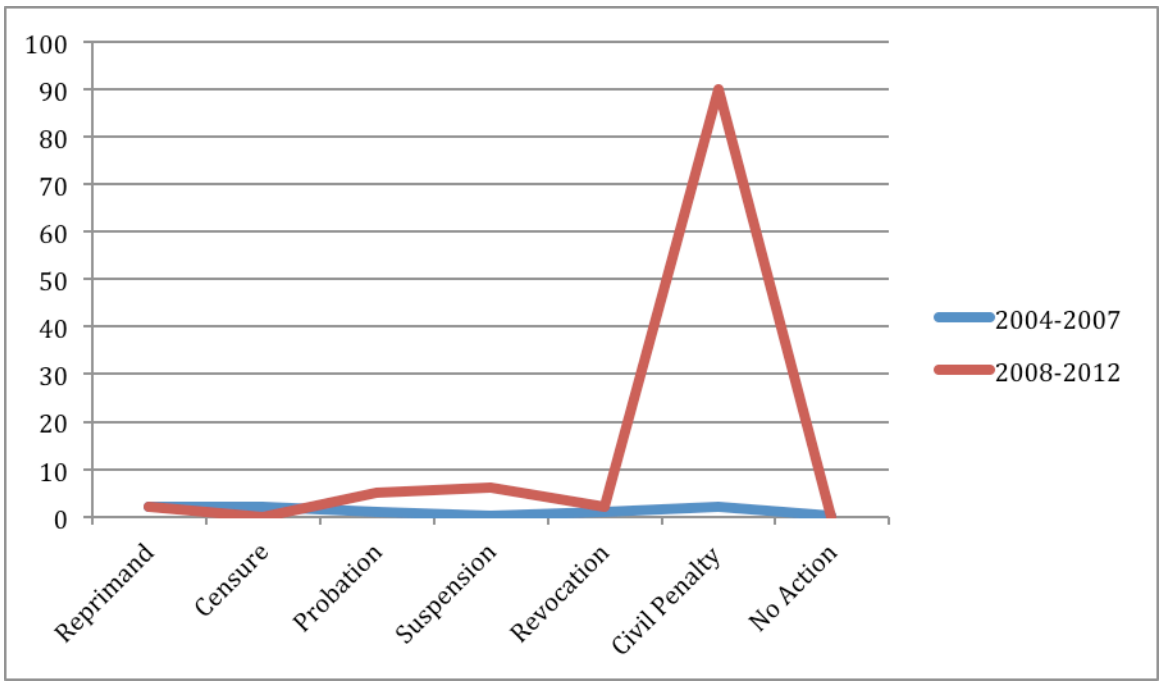


Figure 4.4 Tennessee: Frequency of Disciplinary Action Year and Type

Data Relating to Research Question Two

Data were analyzed to determine the answer to question number two: Is there a difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who received mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners licensed in Alabama who did not receive mandatory ethics and jurisprudence training?

The data examined the same variables for Alabama and Tennessee and found the following results as presented in Table 4.12. Alabama had 26 occupational therapy professionals disciplined out of 1889 licensed therapists (1.4%). Tennessee had 105 occupational therapy professionals disciplined out of a total of 3200 (3.3%) practitioners.

Table 4.12 Year, Number and Percentage of Disciplinary Actions taken against Occupational Therapy Professionals in Alabama and Tennessee 2004-2012

Year of Discipline	TN Disciplinary Actions N	TN Disciplinary Actions %	AL Disciplinary Actions N	AL Disciplinary Actions %
2004	2	1.8	3	7.5
2005	1	0.9	1	2.5
2006	0	.0	6	15.0
2007	3	2.7	4	10.0
2008	1	0.9	5	12.5
2009	43	38.7	4	10.0
2010	15	13.5	8	20.0
2011	28	25.2	5	12.5
2012	18	16.2	4	10.0
TOTAL	111	100	40	100

A chi-square analysis was conducted to evaluate if there was a difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy practitioners licensed in Alabama who did not receive mandatory ethics and jurisprudence training. The percentage of occupational therapy professionals that were disciplined in Tennessee (2008-2012) after ethics and jurisprudence training was implemented was 3.3%% and the percentage of Alabama occupational therapy practitioners disciplined without participating in ethics and jurisprudence training during the same time span was 1.4%. This difference was statistically significant x^2 (1,N=131), =17.186 p< .001. The number of therapists that was used to calculate this difference was based on the total number of all occupational therapy professionals licensed in Tennessee for the year 2012 (3200) and for Alabama it was 1889 total occupational therapy professionals in 2012. This number may not be as accurate as possible due to occupational therapy practitioners retiring or newly

licensed, however, it was determined that this would be the closest approximation of therapists to compare the data.

Data from Alabama and Tennessee licensure records were compared to determine differences when both states did not require ethics and jurisprudence training. Table 4.13 illustrates the frequency of disciplinary reports and the percentage of disciplinary reports for each state during those years. In the time frame of 2004-2007 (no E & J training) Alabama had a higher incidence of disciplinary reports at .934% compared to Tennessee at .235%.

Table 4.13 Frequency of Occupational Therapy Professionals Disciplined and Percentage of Disciplinary Reports taken with E & J Training (Tennessee) and without Training (Alabama) 2004-2012

Calendar Years	OT's Disciplined Alabama (No E & J Training) N	OT's Disciplined Tennessee (E & J Training) N	OT's Disciplined Alabama (No E & J Training) %	OT's Disciplined Tennessee (E & J Training) %
2004-2007	14	6	.934	.235
2008-2012	26	105	1.376	3.28

There were more disciplinary reports for Tennessee during 2008-2012, the years of mandatory ethics and jurisprudence training when compared to Alabama, with no required ethics and jurisprudence. Figure 4.5 shows the difference in frequency of disciplinary reports for Alabama and Tennessee during 2004-2012.

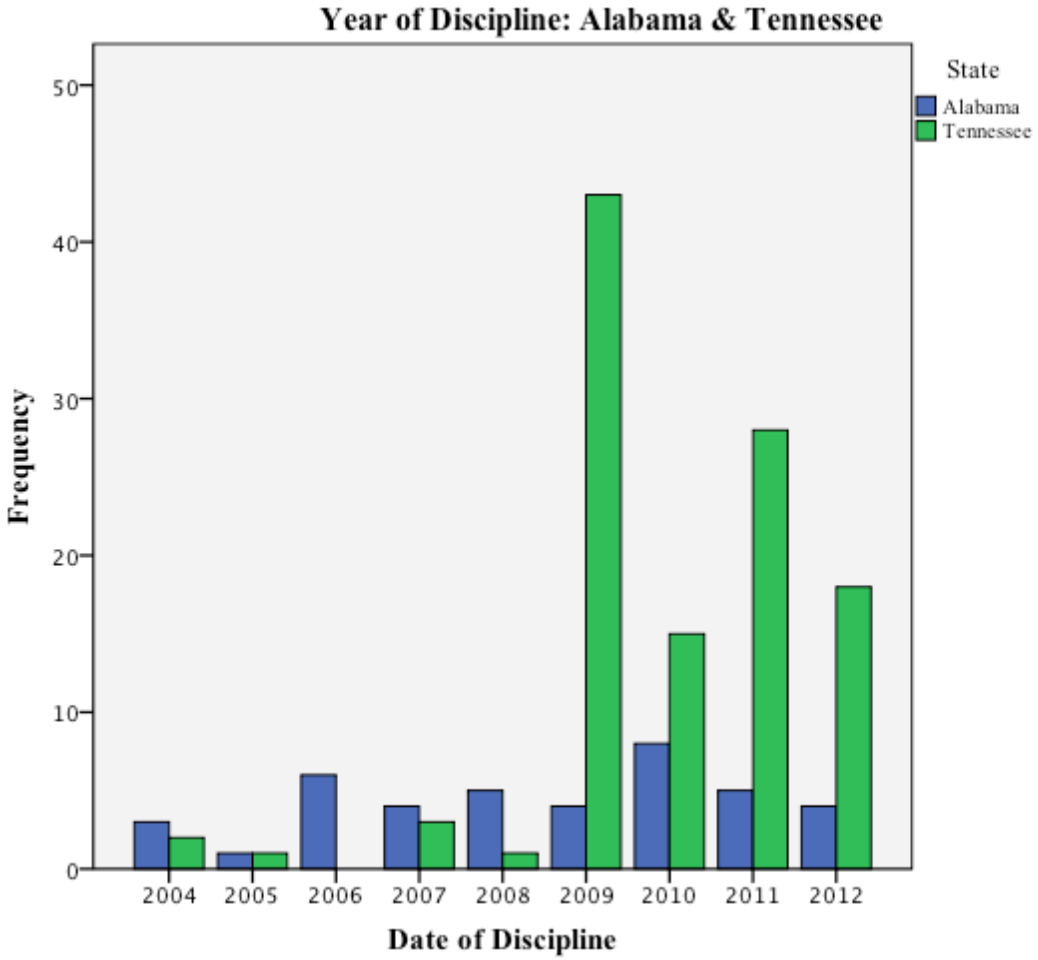


Figure 4.5 Year and Frequency of Discipline for Alabama and Tennessee Occupational Therapy Professionals

To better understand the differences between the two states, the most frequently reported offenses were examined. The most frequently reported types of offenses for Alabama and Tennessee is illustrated in Figure 4.6.

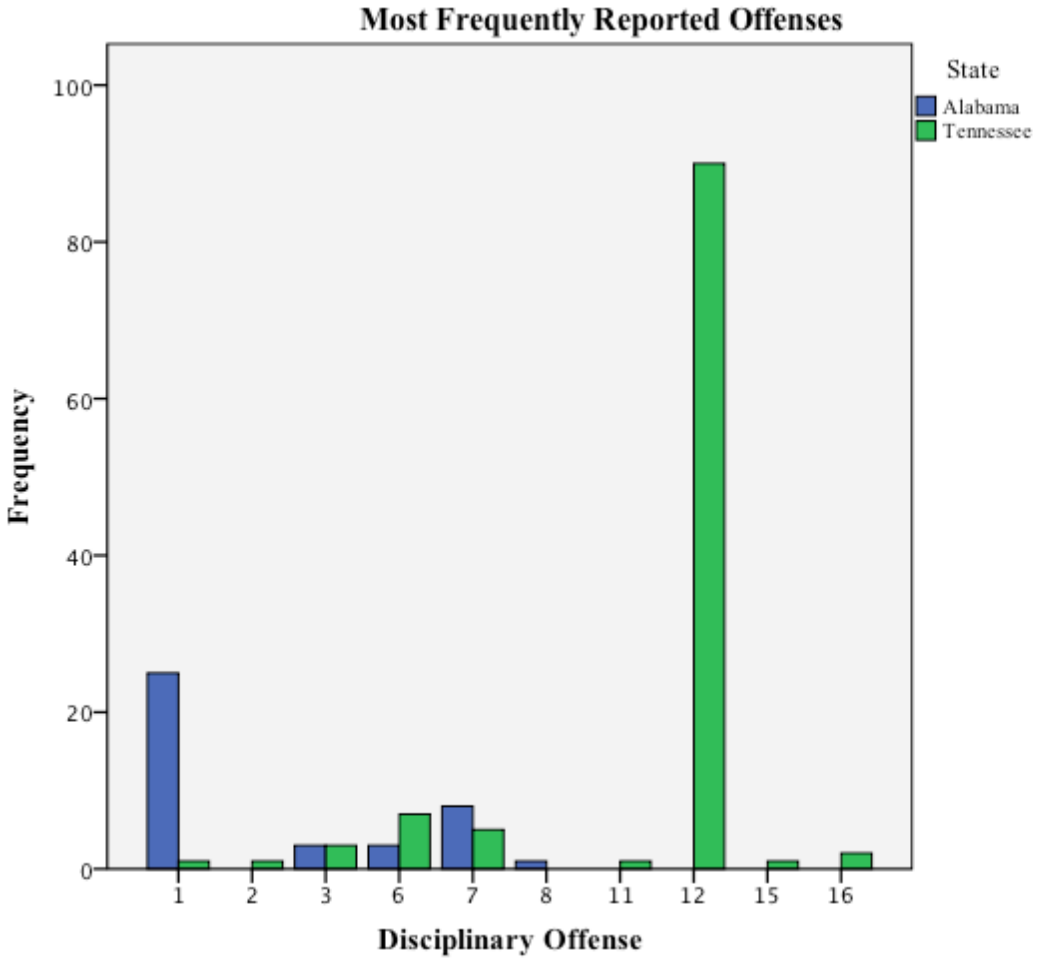


Figure 4.6 Most Frequent Types of Offenses
See Appendix D for Legend that defines Offenses 1-16

The most frequent types of offenses are listed in Table 4.14 for Alabama and Tennessee. Alabama most frequently reported Offense 1 (N=25 or 62.5% of the state's total) (Unprofessional, dishonorable or unethical conduct). Tennessee's most frequently reported offense 12 (N=90 or 81.1% of the state's total) was failure to complete continuing competence requirement.

Table 4.14 Offenses (Violations) Reported for Alabama and Tennessee 2004-2012

Offense	AL N	AL% in State	TN N	TN % in State	Total N	Total %
1	25	62.5	1	0.9	26	17.2
2	0	.0	1	0.9	1	0.7
3	3	7.5	3	2.7	6	4.0
6	3	7.5	7	6.3	10	6.6
7	8	20.0	5	4.5	13	8.6
8	1	0.9	0	.0	1	0.7
11	0	.0	1	0.9	1	0.7
12	0	.0	90	81.1	90	59.6
15	0	.0	1	0.9	1	0.7
16	0	.0	2	1.8	2	1.3
TOTAL	40	100	111	100	151	100

There was a significant increase in the number of offenses and disciplinary reports taken in 2009 as a direct result of audits of occupational therapy professionals license renewal requirements. The most common disciplinary action taken for this offense was a civil penalty and the requirement to complete the continuing competence hours. Figure 4.7 demonstrates the frequency of occupational therapy professionals that failed to meet the mandatory requirement of continuing competence after 2008.

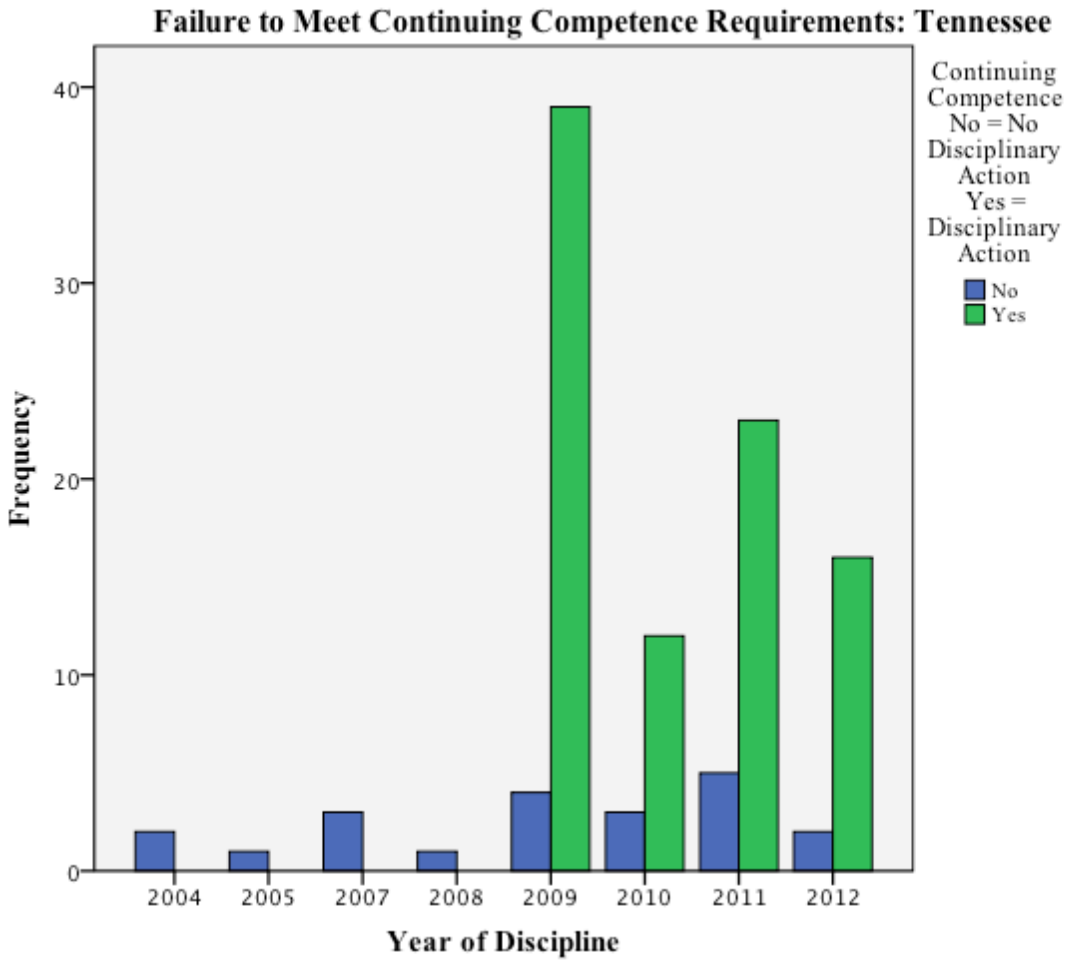


Figure 4.7 Failure to meet Continuing Competence Requirements: Tennessee

There were a total of 90 disciplinary reports for failure to meet continuing competence requirements for the years 2008-2012. Table 4.15 indicates the frequency and percentage of Offense 12 (Failure to meet continuing education requirements) from 2008-2012. There were no disciplinary reports of any type in 2008.

Table 4.15 Failure to Meet Continuing Competence Requirements for Tennessee Occupational Therapy Professionals 2008-2012

Year	Total N	Offenses for the year %
2008	0	.0
2009	39	90.7
2010	12	80
2011	23	82.1
2012	16	88.9
Total Offenses Reported	90	81.1

* No reports of Offense 12 for years 2004-2007 – Continuing education was not mandatory during those years.

The next groups of data that help us understand the differences between the states are the frequency and types of disciplinary actions taken in Alabama and Tennessee. The disciplinary actions reported by Alabama and Tennessee are found in Figure 4.8. Table 4.16 shows the frequency and percentage of all reported disciplinary actions in Alabama and Tennessee from 2004-2012. Alabama's most frequently reported action was no action (22 out of 40 or 55%) followed by probation (10 out of 40, 25%). Tennessee's most frequently reported disciplinary action was civil penalty or financial penalty (92 out of 111, 82.9%) followed by suspension of license (6 out of 111, 5.4%).

Figure 4.8 Most Frequent Types of Disciplinary Actions taken by State

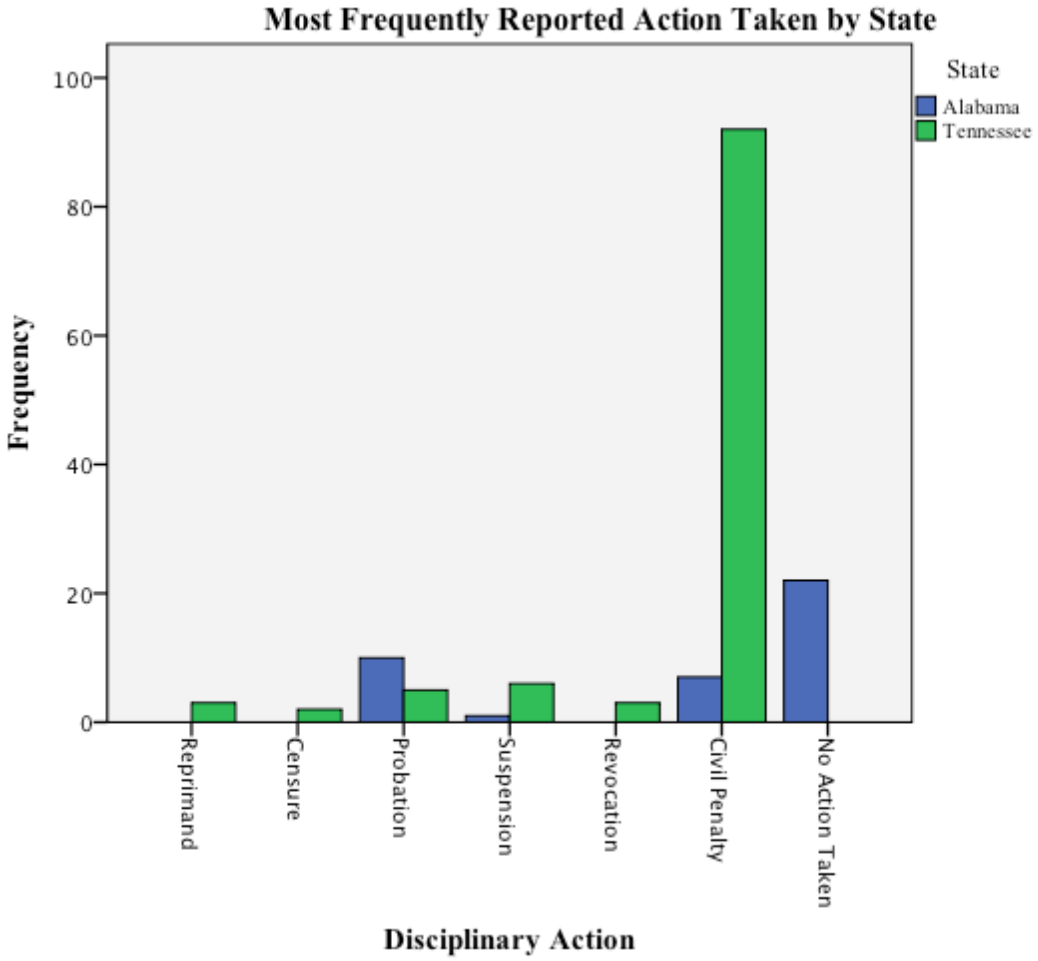


Table 4.16 Disciplinary Actions Taken in Alabama and Tennessee 2004-2012

Action	AL N	AL % in State	TN N	TN % in State	Total N	Total %
Reprimand	0	.0	3	2.7	3	2.0
Censure	0	.0	2	1.8	2	1.3
Probation	10	25.0	5	33.3	14	9.9
Suspension	1	2.5	6	5.4	7	4.6
Revocation	0	.0	3	2.7	3	2.0
Civil Penalty	7	17.5	92	82.9	99	65.6
No Action	22	55.0	0	.0	22	14.6
TOTAL	40	100	111	100	151	100

When reviewing the number of disciplinary reports for occupational therapy professionals it is important to keep the numbers in context. Table 4.17 displays the incidence of disciplinary reports based on the number of licensed occupational therapy practitioners for each year. Alabama had fewer occupational therapy practitioners than Tennessee. It is important to keep this in mind when considering the number of disciplinary reports in each state.

Table 4.17 Incidence of Disciplinary Reports by Year for Occupational Therapy Professionals Based on the Number of Licensed Occupational Therapy Professionals in Alabama and Tennessee

Year	Licensed OT's Alabama N	Licensed OT's Tennessee N	Reports Alabama N	Reports Tennessee N	Incidence Alabama %	Incidence Tennessee %
2004	1322	2246	2	2	.151	.089
2005	1372	2346	1	1	.073	.043
2006	1410	2432	6	0	.425	.0
2007	1499	2554	4	3	.267	.082
2008	1587	2634	5	1	.315	.038
2009	1631	2764	4	43	.246	1.555
2010	1706	2921	8	15	.469	.514
2011	1810	3086	5	28	.277	.91
2012	1889	3200	4	18	.211	.563

These tables and figures have displayed information regarding the demographics of the data collected from Alabama and Tennessee Occupational Therapy regulatory boards for the years 2004-2012. The data from each state was utilized when available to provide these facts.

Summary

This chapter presented the data collected from the Alabama State Board of Occupational Therapy and Tennessee Board of Occupational Therapy specific to disciplinary reports taken in years 2004 – 2012. Data were presented in terms of demographic data from Alabama and

Tennessee. These included demographic information such as professional role (occupational therapist or occupational therapist assistant), gender, education (U.S. or Foreign Trained), years certified prior to disciplinary report, age of therapist when disciplined (only available for Alabama), type and frequency of offenses the therapist had been charged, and type and frequency of disciplinary actions ordered by the regulatory boards. The chapter concluded with the reporting of the statistical analysis completed on the collected data pertaining to the study's research questions.

CHAPTER V

RESULTS AND CONCLUSIONS

The purpose of Chapter 5 is to summarize the data collected from Alabama and Tennessee State Licensure Boards related to mandatory ethics and jurisprudence training. Tennessee mandated continuing competency requirements in 2008, which included ethics and jurisprudence. Tennessee disciplinary data were compared to the disciplinary reports taken by Alabama State Board of Occupational Therapy. Alabama had continuing competency requirement but no obligation to complete additional training in ethics and jurisprudence. This chapter will begin with a review of the research study by summarizing the first three chapters. The central portion will focus on the findings of the study, which will be accompanied by discussion related to the findings of the research questions and relevant literature. The chapter will conclude with implications for the profession and recommendations for future research.

Information about unprofessional conduct of occupational therapy professionals including ethics complaints is useful to state regulators, policymakers, educators, managers, and members of the profession. To ensure that healthcare practitioners abide by the basic standards, state practice acts and codes of professional ethics contain rules that require the individual to comply with the regulation for professional conduct. State licensing boards have the legislative authority to license occupational therapy practitioners when they meet certain conditions. The purpose of licensure is to regulate occupational therapy practice and protect the public from injury by incompetent or unqualified practitioners.

In addition to regulating the practice of occupational therapy, state licensing boards publish rules and regulations to communicate to the licensees and the public about what constitutes acceptable practice. State licensing boards also inform the public about what to do in case of a complaint and, in many cases, publish lists of disciplinary actions taken. According to AOTA (2012) forty- three states and Washington D.C. require licensees to meet competence standards. State licensing boards have the authority to discipline occupational therapy professionals under their jurisdiction or fine licensees, or both, for violations of laws and regulations. This study reviewed the behavior of occupational therapy professionals that justified disciplinary action by state licensing boards in Alabama and Tennessee from 2004-2012. This study compared disciplinary reports before ethics and jurisprudence training was mandated in Tennessee (2004-2007) to disciplinary reports after mandatory ethics and jurisprudence training (2008-2012).

Systems are in place to gather and report data on occupational therapy practitioners that are found to be in violation of ethics and competence requirements. Publishing the results of disciplinary actions is intended to notify and protect the public by identifying occupational therapy professionals that have violated laws, regulations, or best practices. There are several data collection agencies that collect information about occupational therapists and occupational therapy assistants such as NBCOT, AOTA, state regulatory boards and the National Practitioner Data Bank (NPDB). The frequency of disciplinary reports by the Alabama and Tennessee state licensing boards was larger than that reported in the NPDB. This discrepancy may be attributable to several possible reasons; for example, a person reported in more than one state may appear only once in the NPDB, entities incur no legal consequences for not reporting to the NPDB and may not take the time to do so, budget cuts may hinder some states from reporting,

and some state licensing boards report their disciplinary actions to NBCOT rather than to NPDB. The reason for this discrepancy in Alabama and Tennessee was not discovered during this study.

The purpose of the study was to determine whether the mandated ethics and jurisprudence courses resulted in a decrease in the disciplinary reports taken by the Tennessee State Board of Occupational Therapy. In addition, these data were compared to data from the Alabama State Board of Occupational Therapy, which did not have mandatory ethics and jurisprudence training for licensed occupational therapy practitioners in their state.

The review of recent literature documented a shortage of literature on this topic in occupational therapy. There were studies regarding mandatory continuing education for other healthcare providers. Smith (2003) with the National Council of State Boards of Nursing Research Department developed a study to explore if a link existed between mandatory continuing education and the development of professional competence. This study was joined by other regulatory agencies for medical technologists, occupational therapists, physician's assistants, physical therapists and respiratory therapists. There were nine conclusions only specific to nursing.

Papadakis and colleagues (2005) studied disciplinary actions against physicians and prior behavior in medical school. They found that disciplinary action by a medical board was strongly associated with prior unprofessional behavior in medical school.

Physical therapy recently conducted a study looking at disciplinary reports and actions taken by licensing boards during 2000-2009 (Ingram, et al., 2013). Their data were obtained from the Federation of State Boards of Physical Therapy. The database included information from forty-nine of the fifty-three jurisdictions. Individual disciplinary data were not examined and only aggregate data were provided. The authors found that less than 1% of licensed physical

therapists and physical therapy assistants were disciplined. The most common offenses were related to failure to comply with statutory requirements. Other findings from the study included that males were disciplined more frequently than females, and non-U.S. educated physical therapists and male physical therapists were disciplined for more flagrant offenses than expected (Ingram, et al., 2013).

Published studies about the unprofessional conduct of occupational therapy professionals are limited. Scott and Reitz (2013) published a summary of state regulatory disciplinary actions in two states (Maryland and North Carolina) for a one-year period (2010). This data collection was utilized to demonstrate the various disciplinary actions that may be taken by state regulatory boards.

This study presents the results of a descriptive study, synthesizing the reports of two state regulatory boards, Alabama and Tennessee for nine years (2004-2012). This study accessed archival data from both the Alabama and Tennessee Occupational Therapy Licensure Boards. All disciplinary actions are made available to the public for inspection. The study examined these two states in order to compare disciplinary reports over the span of nine years (2004 – 2012). Tennessee's data included pre- and post-mandatory ethics and jurisprudence (E & J) training, while Alabama's data incorporated all disciplinary reports over the same nine years in a state that does require continuing competence but does not require ethics and jurisprudence training. This inspection of disciplinary reports in two different states examined the potential impact of ethics and jurisprudence training for occupational therapy professionals.

The total population was all occupational therapists and occupational therapy assistants in Alabama and Tennessee at the time of data collection. The data included those occupational therapy professionals that had been disciplined by both state boards of occupational therapy from

2004 – 2012. There were 151 disciplinary reports filed from 2004-2012 for both states (AL = 40, TN = 111). The total number of all occupational therapy professionals in 2012 for Tennessee was 3200 and in Alabama there were 1889.

The data collected for each state included professional designation (occupational therapists or occupational therapy assistant), gender, age at the time of the disciplinary action (only available for Alabama), years since graduation from an occupational therapy program, year of disciplinary report, whether they were educated in the United States or foreign trained, frequency and type of reported offenses, and incidence and type of disciplinary actions.

The dataset for Tennessee was collected from the website of the Tennessee State Board of Occupational Therapy and the State Board of Health Professions (Tennessee Department of Health, 2013). The Executive Director, Ann Cosby, was contacted at the Alabama State Board of Occupational Therapy (2013c) to collect the dataset for Alabama. The researcher collected the data from the Alabama State Licensure Board in Montgomery, Alabama. The Executive Director of the Board made the disciplinary reports available to the researcher.

The demographic data were analyzed using SPSS 20.0 in contingency tables (crosstabs). A contingency table looks at whether the value of one variable is associated with or contingent upon that of another. Usually these variables are nominal or ordinal. A two-way contingency table analysis was conducted to evaluate the length of time between certification and discipline, age of Alabama occupational therapy professionals when disciplined, gender, and the frequency of disciplinary offenses and actions that were taken by each state.

The research utilized nonparametric methods of quantitative research. The statistical procedure used was the Chi-square. Chi-square is a common nonparametric procedure that is used when the data is in nominal form. It is a quantitative measure used to determine whether a

relationship exists between two categorical variables. A Chi-square analysis was conducted to evaluate if there was a difference in the percentage of disciplinary reports for occupational therapy professionals licensed in Tennessee who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals in Tennessee prior to mandated ethics and jurisprudence training. A Chi-square analysis was also utilized to answer the question if there was a difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who participated mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals licensed in Alabama who did not receive mandatory ethics and jurisprudence training.

Findings and Discussion

This study was designed using quantitative data. This section will report the findings based on the methodology utilized accompanied by discussions. Demographic data and the research questions will be presented in terms of its descriptive findings along with the statistical analysis.

Demographics

Demographic data were collected to provide an overall description of occupational therapy professionals that had been disciplined in Alabama and Tennessee. In reviewing the data it was found that Alabama had 40 disciplinary reports from 2004-2012 and Tennessee had 111 disciplinary reports for a total of 151 for both states. In Alabama there were 25 disciplined occupational therapists (62.5%) and 15 disciplined occupational therapy assistants (37.5%). In

Tennessee there were 66 disciplined occupational therapists (59.5%) and 45 disciplined occupational therapy assistants (40.5%). Tennessee had a total of 6 disciplinary reports between the years 2004-2007 before mandatory ethics and jurisprudence training and continuing competency requirements. After mandatory ethics and jurisprudence training, Tennessee had 105 disciplinary reports during 2008-2012. Disciplined occupational therapists from both states totaled 91 (60.3%) and there were 60 (39.7%) disciplined occupational therapy assistants for both states. The percentage of all licensed occupational therapists when compared to all occupational therapy assistants in 2012 in Alabama was 1239 occupational therapists (66%) and 650 occupational therapy assistants (34%). In Tennessee there were a total of 2109 (66%) licensed occupational therapists in 2012 and a total of 1091 occupational therapy assistants (34%). The percentages of disciplined occupational therapists were greater for both Alabama (62.5%) and Tennessee (59.5%). Based on these percentages of all occupational therapists (66%) and all occupational therapy assistants (34%) for both states, the frequency of disciplinary reports should be expected to be distributed similarly for occupational therapists and occupational therapy assistants. The percentages of disciplined occupational therapists were lower than the total population of all for occupational therapists in both Alabama (62.5%) and Tennessee (59.5%) and higher for the total of all occupational therapy assistants (Alabama 37.5%, Tennessee, 40.5%). Based on 2010 survey results from state regulatory boards, the American Occupational Therapy Association (AOTA) estimated the current active occupational therapy workforce to be roughly 137,000 practitioners. This includes approximately 102,500 or 75% occupational therapists and 34,500 or 25% occupational therapy assistants (AOTA, 2013). The percentages of disciplinary reports for Alabama and Tennessee were also lower than the

national percentages for occupational therapists (75% vs. AL 62.5% and TN 59.5%) and higher for occupational therapy assistants (25% vs. AL 37.5% and TN 40.5%).

There were 151 occupational therapy professionals that were disciplined in both Alabama and Tennessee from 2004-2012. There were 34 males (22.5%) and 117 females (77.5%) disciplined from both states during this time period (Table 4.2). There was no data to compare the total numbers of licensed occupational therapy professionals by gender in Alabama and Tennessee. A 2010 AOTA survey indicated that 92% of occupational therapy practitioners were female and 8% were male (AOTA, 2013). The frequency of disciplinary reports of male occupational therapy professionals in Alabama and Tennessee had a higher occurrence (22.5%) than the percentage of the general population of male occupational therapy practitioners (8%), according to a 2010 AOTA survey (AOTA, 2013).

Data were collected during this nine- year time frame reviewing occupational therapy professionals that had been educated in the United States or foreign trained for both Alabama and Tennessee. There were only 3 foreign trained occupational therapists of the total 151 reported cases of disciplined therapists. All of the three foreign trained occupational therapists were licensed in Tennessee. There were no foreign trained occupational therapy assistants. Thus, a formal analysis was not conducted due to low cell frequency.

When examining the data for both states, the most frequently reported years of experience at the time of the disciplinary action was year 13 with a total of 14 disciplinary reports for both states. This number accounted for 9.3% of all Tennessee's disciplinary reports and 10% in Alabama. The second most occurring number of years between initial licensure and disciplinary reports in Tennessee was 18 years for 7.2% of the total. Alabama's second most frequent was 1, 10, 11, 12, and 16 years at 3 occurrences per year each accounting for 7.5% of

the total. Finally, the third most frequent years of initial license and time of discipline for Tennessee was 5 and 10 years, each with 7 occurrences per year accounting for 6.3% of Tennessee's total. Alabama's third most prevalent was 3, 8, and 15 years with 2 occurrences per year accounting for 5% of the total per year.

The age of the therapist when disciplined was only analyzed for Alabama. The dataset from the Alabama State Board of Occupational Therapy included each therapist's birthdates. This information was not available for Tennessee occupational therapy professionals. The mean age was 41.35 years, the median and the mode for the most frequent age was 42 years with 4 cases.

The most frequent types of offenses were analyzed showing Alabama's most frequently reported offense as Offense 1 (Unprofessional, dishonorable or unethical conduct) (N=25 or 62.5% of the state's total). Tennessee's most frequently reported offense was Offense 12 (Failure to comply with continuing competence requirements) (N=90 or 81.1% of the state's total).

The most frequent types of disciplinary actions were analyzed using a two-way contingency table analysis. Alabama's highest reported disciplinary action was no action (22 out of 40 or 55%) followed by probation (10 out of 40, 25%). Tennessee's highest reported disciplinary action was civil penalty or fine (92 out of 111, 82.9%) followed by suspension of license (6 out of 111, 5.4%).

Discussion of Research Question One

The analysis of data to answer question number one "is there a difference in the percentage of disciplinary reports for occupational therapy professionals licensed in Tennessee

who participated in mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals in Tennessee prior to mandated ethics and jurisprudence training" was conducted and revealed the following results. Tennessee had a higher percentage (94.5%) of all disciplinary reports for the five-year period after ethics and jurisprudence training was made mandatory when compared to no training in years 2004-2007 (5.4%). There was a significant increase in the number of disciplinary reports in 2009 in Tennessee. This increase resulted from an audit of licensees for evidence of continued competence requirements. A chi-square analysis was conducted to assess if there was a difference in the percentage of occupational therapy professionals that participated in ethics and jurisprudence training and the number of disciplinary reports for Tennessee occupational therapy professionals for the years 2008-2012 and those therapists that did not participate in ethics and jurisprudence training and the number of disciplinary reports for the years 2004-2007. The percentage of all occupational therapy professionals that were disciplined in Tennessee before (2004-2007) ethics and jurisprudence training was 0.2% and the percentage of all occupational therapy professionals disciplined after ethics and jurisprudence training was 3.3%. This difference was statistically significant x^2 (1,N=111), =69.672p< .001. The number of occupational therapy professionals used to calculate this difference was based on the total number of occupational therapy practitioners licensed in the state in 2012, as reported by the Tennessee Occupational Licensure Board. This number may not be as accurate as possible due to practitioners retiring or newly licensed, however, it was determined that this would be the closest approximation of practitioners to compare the data.

As a result of the increase in the incidence of this offense, the Tennessee Occupational Therapy Licensure Board ratified a Board Policy regarding Continuing Competence (See

Appendix C). This policy addressed the consequences and penalty for this infraction of the licensure law. There were no failures to meet continuing competence requirements prior to 2008, as it was not a condition for licensure. The requirement became mandatory in 2008.

There are several possible explanations for the increase in disciplinary reports after the implementation of ethics and jurisprudence. There could have been a Hawthorne effect. The moral of the Hawthorne effect is that people change their behavior when they think you are watching it (Gale, 2004). The occupational therapy professionals may have been more aware of the Code of Ethics and the Tennessee Occupational Therapy Practice Act. This knowledge may have made the practitioners aware of possible infractions so they may have self-reported or reported their colleagues more frequently as a result of the training or the Board was more aware and actively investigated. Another possible cause may have been the lack of awareness of the occupational therapy professionals in Tennessee regarding the continuing competency requirement and consequences of not fulfilling the requirement for licensure renewal. This trend may alleviate as the population of occupational therapy professionals in the state become more aware of this requirement. This study was conducted for five years after the date of the requirement for continued competence, which included two hours of ethics and jurisprudence training. Licensure for occupational therapy practitioners in Tennessee has been required since 1983; however, between 1983 and 2008 continuing competence was not required for license renewal.

Discussion of Research Question Two

The analysis of data to answer question number two "is there a difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who

received mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals licensed in Alabama who did not receive mandatory ethics and jurisprudence training" was conducted and revealed the following results.

The data indicates that Tennessee had a higher percentage (3.3%) of disciplinary reports after mandatory ethics and jurisprudence training was made mandatory when compared to Alabama (1.4%). A chi square analysis was conducted to assess if there was a difference in the percentage of disciplinary reports for occupational therapy professionals in Tennessee who received mandatory ethics and jurisprudence training compared to the percentage of disciplinary reports for occupational therapy professionals licensed in Alabama that did not receive mandatory ethics and jurisprudence training. The percentage of occupational therapy professionals that were disciplined in Tennessee before (2008-2012) ethics and jurisprudence training was 3.3%% and the percentage of Alabama occupational therapy professionals disciplined without participating in ethics and jurisprudence training during 2008-2012 was 1.4%. This difference was statistically significant x^2 (1,N=131), =17.186 p< .001. The number of therapists used to calculate this difference was based on the total number of all occupational therapy professionals licensed in Tennessee for the year 2012 (3200) and Alabama had 1889 occupational therapy professionals in 2012. This number may not be as accurate as possible due to therapists retiring or newly licensed, however, it was determined that this would be the closest approximation of therapists to compare the data.

When the data from Alabama and Tennessee are compared for the years both states did not have ethics and jurisprudence (2004-2007), Alabama had a higher incidence of disciplinary reports at .934% compared to Tennessee at .235%.

Alabama's most frequently reported offense was Offense 1 (N=25 or 62.5% of the state's total), which was unprofessional, dishonorable or unethical conduct. Tennessee's most frequently reported offense was Offense 12 (N=90 or 81.1% of the state's total) which was failure to complete continuing competence requirement.

The next groups of data that help us understand the differences between the states are the frequency and types of disciplinary reports taken in Alabama and Tennessee. Alabama's most frequently reported action was no action (22 out of 40 or 55%) followed by probation (10 out of 40, 25%). Tennessee's most frequently reported disciplinary action was civil penalty or financial penalty (92 out of 111, 82.9%) followed by suspension of license (6 out of 111, 5.4%).

Implications for the Profession

There are many implications for the professions as a result of this study. The outcome of this study indicated that the introduction of mandatory ethics and jurisprudence training for Tennessee occupational therapy professionals showed an increase in the incidence of disciplinary reports rather than a decrease in disciplinary reports.

Tennessee occupational therapy professional's knowledge of licensure renewal may take some time before it becomes automatic in planning for renewal. Tennessee occupational therapy professionals have required licensure since 1983. The only requirement, prior to 2008, for licensure renewal was to complete the renewal application and pay the licensure fee. The requirement of continuing competence became mandatory in January 2008, which included one hour of ethics and one hour of jurisprudence training as part of licensure renewal. Each licensed occupational therapy professional was notified by mail of the new requirements in 2006. The occupational therapy practitioner may not have been aware of the possible sanctions for failure to

complete the required competence or just willingly chose not to complete the requirements. Alabama has had licensure for their therapists since 1990. Continuing competence had been a requirement for licensure renewal in Alabama since the inception of their licensure. The data for Alabama may have also shown an increase in disciplinary reports immediately following the implementation of continuing competence. These data were not examined in this study.

Disciplinary actions taken against occupational therapy professionals should be made more easily available to the public for inspection. In some states the information is easily accessible and others not at all. Even though it is required for health care boards to report disciplinary actions to the National Practitioner Data Bank, there appears to be an inconsistency in how each state chooses to report the information or the information is not reported at all.

Limitations of the Study

The limitations of this study include several factors. One important limitation is the availability of information that was accessible to the researcher. Alabama and Tennessee Occupational Therapy Licensure Boards disciplinary reports are public information, but the information provided to the public varies. Each state board can choose the information to provide to the public and to whom the information will be made available. The study population was limited to occupational therapists and occupational therapy assistants licensed to practice in the states of Alabama and Tennessee. While the codes of ethics for both states are similar, the state governing boards are bound by differing rules and regulations.

The study was limited by the short timeframe during which the data were collected. The data only spans nine years. Tennessee occupational therapy professionals were given a two-year notice prior to the enforcement of continuing competence, which included ethics and

jurisprudence training. This study provided an initial synopsis of the immediate impact (2008-2012 – five years) of mandatory continuing competence including ethics and jurisprudence, which might have influenced the increase in the incidence of disciplinary reports.

There are many other factors that could have influenced this study. The accuracy of the data could have been affected by clerical errors. Tennessee and Alabama licensing boards could have been inconsistent in determining the categories of disciplinary actions. There could be missing data that the author cannot verify. The researcher only utilized the data that were available at the time of this study.

Future Research

As a result of this study, the following recommendations are made for future research. There are three areas of future research to be considered: data collection, study focus and instructional design and training.

The potential for future research in the area of data collection are numerous. This study was conducted utilizing data from two Southern states. Future research could include data collection from a larger population of occupational therapy professionals. The study could examine data from disciplinary reports of occupational therapy professionals regionally or nation-wide.

A more focused study could provide an in-depth review of the types of offenses that are committed by occupational therapy professionals and subsequent disciplinary actions taken by state regulatory boards. The examination of unprofessional behaviors while in occupational therapy school compared to future disciplinary actions could add to the knowledge of unethical behaviors by occupational therapy professionals. This study only examined data from two

southern states. Data could be collected from the American Occupational Therapy Association and/or from the National Board for Certification in Occupational Therapy for review of common unprofessional behaviors. This could provide a sample of the larger occupational therapy profession and provide insight to infractions and disciplinary actions nationally.

An assessment of instructional design utilized for teaching of ethics and jurisprudence to licensees is warranted. This study could examine the effectiveness of the instruction and subsequent retention of information by occupational therapy professionals. Another aspect of training is the education of the occupational therapist and occupational therapy assistant students. Educating students to be ethical practitioners is a requirement for accreditation of occupational therapy education programs by the Accreditation Council for Occupational Therapy Education (ACOTE). According to the Standard in Section B. 9.0 occupational therapy programs are responsible for teaching "professional ethics, values, and responsibilities", including "an understanding and appreciation of ethics and values of the profession of occupational therapy" (ACOTE, 2012, p. S570). The expectation of the level of ethics knowledge varies by the degree program (i.e., doctoral, masters or assistant occupational therapist). The requirement for ethical behavior is also included in the preamble to the ACOTE documents for all degree level programs, which reads, "A graduate from an ACOTE-accredited… program must…uphold the ethical standards, values, and attributes of the occupational therapy profession" (ACOTE, 2012, p. S7). It is imperative that occupational therapy faculty help students develop ethical and moral behaviors while in academic programs.

Conclusions

The amount of research and knowledge that health care professionals are expected to know is exponentially increasing. Regulatory boards are challenged to assure that their licensees are staying up to date with new knowledge, research, practice and information as continuing competence is essential to safe patient care. One method that is often regulated is mandatory continuing competence. Research indicates that professionals do not necessarily use continuing competence to fill gaps in their knowledge. In addition, poor performers are poor self-assessors and less likely to recognize their weaknesses and select continuing competence offerings that will improve knowledge and practice (Regehr & Eva, 2006).

The results of this study indicate that mandatory ethics and jurisprudence training did not result in a decrease in disciplinary actions; however, the data may not be telling the entire story. There were other variables that may have influenced the outcome of this study, such as the implementation of mandatory continuing competence after many years of not requiring continuing competence for license renewal in Tennessee.

Professional ethics are important in occupational therapy because of the profession's high risks. Codes of ethics are important when knowing the difference between right and wrong is not enough, and situations arise around patient's rights, patients' dignity, equitable access to treatment and the development of new medical technologies. Codes of ethics help ensure that occupational therapy professionals make the best choices when faced with difficult decisions. Just being aware of the law (jurisprudence training) does not always give the occupational therapy practitioner enough guidance to solve ethical dilemmas. Occupational therapy practice acts dictate the minimum standard of care that states will allow rather than helping the occupational therapy professional determine how to give the highest standard of care. Codes of

ethics pick up where the law leaves off, guiding practitioners to the best solutions, not just requiring them to respect the legal rights of their clients.

The practice of requiring ethics and jurisprudence training is a good faith effort on the part of state regulatory boards to protect the public and ensure the safety of the recipients of occupational therapy services. Making good ethical decisions requires a trained compassion to ethical issues and a skillful method for exploring the ethical aspects of a decision and weighing the considerations that should influence a choice of action. Having a method for ethical decision -making is absolutely fundamental for occupational therapy professionals. When state regulatory boards mandate participation in ethics and jurisprudence training in order to practice (Tennessee requires training every two years), the expected outcome is for the analysis to become familiar and more automatic when the occupational therapy professional is faced with an ethical dilemma.

The results of this study contributed to the existing body of literature regarding disciplinary actions of occupational therapy professionals. The data addressed the disciplinary reports of two states, Tennessee, before and after the implementation of mandatory ethics and jurisprudence training, and Alabama, which had mandatory continuing competence but no ethics and jurisprudence requirement. The implications of this research has the potential to impact state regulatory board's rules and regulations regarding continuing competence as well as occupational therapy academicians as they provide ethical training of future occupational therapy professionals.

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APPENDIX A

IRB # 13-090 – MANDATORY ETHICS AND JURISPRUDENCE TRAINING

THE UNIVERSITY of TENNESSEE CHATTANOOGA

Institutional Review Board
Dept. 4915
615 McCallie Avenue
Chattanooga, TN 37403-2598
Phone: (423) 425-5867
Fax: (423) 425-4052
instrb@utc.edu
http://www.utc.edu/irb

MEMORANDUM

TO: Susan McDonald
Dr. Valerie Rutledge

IRB # 13-090

FROM: Lindsay Pardue, Director of Research Integrity
Dr. Bart Weathington, IRB Committee Chair

DATE: June 17, 2013

SUBJECT: IRB # 13-090 – Mandatory Ethics and Jurisprudence Training: Does it Make a Difference in Disciplinary Actions for Occupational Therapists?

The IRB Committee Chair has reviewed and approved your application and assigned you the IRB number listed above. You must include the following approval statement on research materials seen by participants and used in research reports:

The Institutional Review Board of the University of Tennessee at Chattanooga (FWA00004149) has approved this research project # 13-090

Since your project has been deemed exempt, there is no further action needed on this proposal unless there is a significant change in the project that would require a new review. Changes that affect risk to human subjects would necessitate a new application to the IRB committee immediately.

Please remember to contact the IRB Committee immediately and submit a new project proposal for review if significant changes occur in your research design or in any instruments used in conducting the study. You should also contact the IRB Committee immediately if you encounter any adverse effects during your project that pose a risk to your subjects.

For any additional information, please consult our web page http://www.utc.edu/irb or email us at: instrb@utc.edu .

Best wishes for a successful research project

APPENDIX B

ALABAMA STATE BOARD OF OCCUPATIONAL THERAPY

Alabama State Board of Occupational Therapy
P.O. Box 3926 334-353-4466 Montgomery, AL 36109-0926

June 10, 2013

TO WHOM IT MAY CONCERN:

Susan McDonald, OT has contacted this office in regards to her research of disciplinary actions.

We will be glad to assist her with information regarding complaints filed, and disciplinary actions rendered by this board for the years 2004 – 2012.

Sincerely,

Ann Cosby

Ann Cosby
Executive Director

APPENDIX C

TENNESSEE BOARD OF OCCUPATIONAL THERAPY

POLICY STATEMENT:

CONTINUED COMPETENCE

TENNESSEE BOARD OF OCCUPATIONAL THERAPY

Policy Statement: Continued Competence

Occupational Therapists and Occupational Therapy Assistants in Tennessee are required to demonstrate continued competence by obtaining twenty-four (24) continued competence credits in the two (2) calendar years that precede the licensure renewal year. (Please refer to the Board's rule Tenn. Comp. R. & Regs. 1150-2-.12 for complete information regarding the continued competence requirements.)

Should the Tennessee licensed Occupational Therapist or Occupational Therapy Assistant fail to comply with the continued competence requirement for the two (2) calendar year period preceding the licensure renewal year, the following shall occur:

1. The licensee will be accessed a civil penalty in the amount of one hundred dollars ($100.00). Payment is due within thirty (30) days of notification from the Board.

2. The licensee must make up the deficient continued competence credit hours within the following calendar year. These deficient hours are in addition to the twenty-four (24) continued competence credit hours required in the current renewal cycle. Documented proof must be submitted to the Board upon completion.

Failure to comply with the continued competence requirement may result in disciplinary action. Failure to respond to a Board request for documentation or to make up deficient continued competence credit hours after notification by the Board may result in disciplinary action.

Ratified by the Board of Occupational Therapy on March 12, 2009.

Janet M. Neely, COTA/L
Chair, Tennessee Board of Occupational Therapy

Retrieved from: https://health.state.tn.us/Boards/OT/PDFs/OT_ContinuingCompetency.pdf

APPENDIX D

LIST OF OFFENSE CODES FOR ALABAMA AND TENNESSEE

List of Offenses for Alabama and Tennessee

(1) Unprofessional, dishonorable or unethical conduct;

(2) Violation or attempted violation, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part or any lawful order of the board issued pursuant thereto, or any criminal statute of the state of Tennessee;

(3) Making false or misleading statements or representations, being guilty of fraud or deceit in obtaining admission to practice, or being guilty of fraud or deceit in the licensee's practice;

(4) Gross malpractice, or a pattern of continued or repeated malpractice, ignorance, negligence or incompetence in the course of professional practice;

(5) Habitual intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances or other drugs or stimulants in such a manner as to adversely affect the person's ability to practice;

(6) Conviction of a felony, conviction of any offense under state or federal drug laws, or conviction of any offense involving moral turpitude;

(7) Making or signing in one's professional capacity any certificate that is known to be false at the time one makes or signs such certificate;

(8) Engaging in practice when mentally or physically unable to safely do so;

(9) Solicitation by agents or persons generally known as "cappers" or "steerers" of professional patronage or profiting by the acts of those representing themselves to be agents of the licensee;

(10) Division of fees or agreeing to split or divide fees received for professional services with any person for bringing or referring a patient;

(11) Conducting practice so as to permit, directly or indirectly, an unlicensed person to perform services or work that, under the provisions of this part, can be done legally only by persons licensed to practice;

(12) *This offense number was used for failure to complete continuing education requirements. This following offense was never recorded as an offense by either Tennessee or Alabama occupational therapists.* Professional connection or association with any person, firm or corporation in any manner in an effort to avoid and circumvent the provisions of this part, or lending one's name to another for illegal practice;

(13) Payment or acceptance of commissions, in any form or manner on fees for professional services, references, consultations, pathological reports, prescriptions or on other services or articles supplied to patients;

(14) Giving of testimonials, directly or indirectly, concerning the supposed virtue of secret therapeutic agents or proprietary preparations, such as remedies, or other articles or materials that are offered to the public, claiming radical cure or prevention of diseases by their use;

(15) Violating the code of ethics adopted by the board;

(16) Any other unprofessional or unethical conduct that may be specified by the rules duly published and promulgated by the board, or the violation of any provision of this part (this was coded for failure to pay student loans);

(17) On behalf of the licensee, the licensee's partner, associate, or any other person affiliated with the licensee or the licensee's facility, use or participate in the use of any form of public communication containing a false, fraudulent, misleading or deceptive statement or claim; or

(18) Disciplinary action against a person licensed to practice occupational therapy by another state or territory of the United States for any acts or omissions that would constitute grounds for discipline of a person licensed in this state. A certified copy of the initial or final order or other equivalent document memorializing the disciplinary action from the disciplining state or territory shall constitute prima facie evidence of violation of this section and be sufficient grounds upon which to deny, restrict or condition licensure or renewal and/or discipline a person licensed in this state.

VITA

Susan Spratling McDonald was born in Savannah, Georgia, to the parents of John and Peggy Spratling. She is the first of three girls. Her father was in the Air Force and they traveled throughout the United States and the world during her childhood. She graduated from the University of Alabama at Birmingham with a Bachelor of Science degree in Occupational Therapy and a Master of Education in Rehabilitation Science. She has been a practicing occupational therapist working with many populations; psychiatry, adult rehabilitation, hands, pediatrics, and finally in academia teaching occupational therapy. She completed her Ed.D. in Learning and Leadership at the University of Tennessee at Chattanooga in 2013. Susan is currently employed as the Program Director of the Occupational Therapy Doctoral Program at the University of Tennessee at Chattanooga. She is married to Dr. David McDonald and has two children, Paul and Beth. She loves spending time with her family and in her spare time enjoys reading and traveling.